Maternal and Child Health Services
Title V Block Grant

State Narrative for Colorado

Application for 2010
Annual Report for 2008

Document Generation Date: Monday, September 28, 2009

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The Appropriate Assurances and Certifications for non-construction programs, debarment and suspension, drug-free work place, lobbying, program fraud, and tobacco smoke, that are part of this grant, are maintained on file as required by the block grant guidance at the State's MCH administrative office on the fourth floor at the Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South, Denver, Colorado 80246.

/2008/ No changes //2008//

/2009/ No changes //2009//

/2010/ No changes //2010//

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Colorado first placed online for review and public input its FY 2000 Maternal and Child Health Block Grant in 1999. Since that time, all narratives have been placed online. Users find online access to the grant very convenient, and comments throughout the year are solicited through a return email function on the Web site.

Much input was sought last year for the FY 2006 grant application through the intensive needs assessment process that was conducted. This process was described in detail in the needs assessment section (Section II).

A draft version of the FY 2007 grant application was placed on the state health department's Web site on June 22, 2006. Comments were solicited by external reviewers and appropriate changes were made in the final grant application before the July 17, 2006 submission.

After transmittal to the Maternal and Child Health Bureau, the final version of the Maternal and Child Health Application/Annual Report for FY 2007 will be available on the department Web site. Visitors to the Web site will be able to download the application and will be able to email the Division with their comments and questions throughout the year. Hard copies will also be available. A map of Colorado is attached to this section to assist the reader when county and place name references are used in the grant application.

/2008/
A draft version of the FY 2008 grant application was placed on the state health department's Web site on June 26, 2007. Comments were solicited by external reviewers and appropriate changes were made in the final grant application before the July 17, 2007 submission.

After transmittal to the Maternal and Child Health Bureau, the final version of the Maternal and Child Health Application/Annual Report for FY 2008 will be available on the department Web site. Visitors to the Web site will be able to download the application and will be able to email the Division with their comments and questions throughout the year. Hard copies will also be available. A map of Colorado is attached to this section to assist the reader when county and place name references are used in the grant application. //2008//

/2009/ Activities described for 2008 will be done again this year.//2009//

/2010/ Activities described previously will be repeated this year. No comments were received on the posted draft block grant application.//2010//

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The 2005 Colorado needs assessment process began with the development of The Health Status of Colorado's Maternal and Child Health Population Report. This coincided with a series of state and local stakeholder input sessions and meetings of a state workgroup. These meetings led to the identification of needs; assessment of the state and local MCH capacity to address these needs; and selection of the top priorities to be addressed with Maternal and Child Health (MCH) funding. The development of strategic plans, which identify specific activities for state and community-level initiatives, began in the spring of 2005.

Guidance for the development of county MCH plans was incorporated into contracts for local health departments. The county public health departments were asked to develop annual MCH plans, setting objectives and activities that addressed one or more of the state's MCH priorities and related performance measures. The state provides county-specific MCH data profiles each year for local public health agencies to use as they developed their annual county MCH plans. The profiles include data for the nearly 30 MCH performance and seven outcome measures where such data were available at the county or regional level.

The local agencies were asked to use the data provided by the state and other relevant data sources when deciding what priorities to address in their MCH Plans. They also submit a six-month progress and a year-end final report outlining their successes and challenges in completing the activities and achieving the objectives.

The Health Status of Colorado's Maternal and Child Health Population summarized Colorado data and compared it to national information. Twelve areas associated with women's and children's health needing improvement were identified.

1. Access to prenatal care
2. Alcohol use among pregnant women and teens
3. Low birth weight
4. Immunizations
5. Motor vehicle injury for teens and in rural areas
6. Teen suicide
7. Hispanic teen fertility
8. Access to care for children with special health care needs
9. Lack of access to oral health care for children
10. Lack of insurance for oral health care for children
11. Lack of health insurance for women and children
12. Lack of access to mental health care for children, adolescents, and women.

MCH stakeholders participating in an electronic and phone-based input process reinforced the importance of the issues listed above. The process also identified the following issues of high importance.

•Perinatal period: unintended pregnancy, smoking, inadequate weight gain, drug use during pregnancy, prematurity, infant mortality, and breastfeeding initiation
•Access to health care: lack of insurance for prenatal care; for children and especially those with special health care needs; and lack of access to family planning for adolescents and young women
•Secondhand smoke exposure

•Intentional (child abuse and neglect) and unintentional injury among children
•Overweight among women and children
•Adolescent smoking, alcohol and illegal substance use

The workgroups associated with the planning process identified focus areas relevant to specific populations or types of services to address when working on a priority need. For example, under the Access to Care priority, there are four focus areas that will be addressed in the development of the strategic plan for that priority need. They include access to primary care for all children; access to specialty care for children and youth; access to mental health services for children, youth and women; and access to oral health care for children. The ten state performance measures selected are discussed in the Priorities, Performance and Program Activities Section.

The ten priority needs address all three major MCH population groups. Preventive and primary care for women, mothers and infants are addressed through eight of the priorities. Preventive and primary care for children are addressed through nine of the priorities. Services for children with special health care needs are addressed through two of the priorities.

Current activities
In the last year, the program has been developing state level plans that address the ten priority areas.

Work is under way to review current activities and ensure they are still relevant based upon data and state needs. Staff are working to clarify their focus within three program areas thus ensuring the most benefit from MCH funding and activities.

Another major initiative influencing work this year was the development of a MCH Planning Process Workgroup. The MCH Director convened the workgroup to examine how to improve planning systems and processes associated with the use and distribution of MCH funding to local contractors.

The Workgroup met six times from June through September 2006, and drafted 20 recommendations. As a result of this process, three smaller workgroups (Strategic Planning, Model Plans, and Training & Technical Assistance) composed of state and local MCH staff were convened. These groups are working to operationalize and then implement the recommendations from the report. (Attachment). Additionally, state staff are engaging in a critical review of state-level MCH activities during the summer and fall to better re-define priorities and work at the state level in response to data trends and MCH funding reductions.

/2009/MCH Local Planning Process Improvement. MCH state staff successfully completed an 18-month collaborative effort with local public health partners to revise the MCH local planning process. The goal was to promote a systematic process of planning, implementation and evaluation for use in the development of MCH plans at the local level and to assure that plans were in alignment with the MCH performance measures. Over the course of the next three years, all local agencies will move to completing a 3-year MCH plan with annual updates. To this end, processes and forms were jointly crafted to assure that data were available for use in decision-making and joint state and local planning processes were implemented to assure that local plans utilized evidence-based and/or promising practice strategies with explicit goals, objectives, and activities. The importance of both process and outcome evaluation was highlighted throughout the work group process. Local agencies will complete their plans utilizing this new process as of 7/1/08. Detailed instructions are included within the MCH Guidelines located at www.mchcolorado.com and at www.hcpcolorado.com.

A state-level trend analysis was developed (attached). //2009//

/2010/ Work continues on implementing the 3-year planning process described above. The MCH County Datasets continue to be updated each year, and are used by many counties

as a starting point for describing county health status. The datasets can be accessed at www.cdphe.state.co.us/ps/mch/mchdatasets.html.

A number of new MCH Action Guides have been developed and posted at www.mchcolorado.org.

Planning has begun for the 5-year MCH Block Grant Needs Assessment process. An Advisory Committee composed of state and other stakeholders has been convened. A Steering Committee is guiding the process under the coordination of the MCH Director.//2010//

III. State Overview

A. Overview

Introduction

The Rocky Mountain state of Colorado is bounded on the east by Kansas and Nebraska, on the north by Nebraska and Wyoming, on the west by Utah and on the south by New Mexico and Oklahoma. The boundary lines create an almost perfect rectangle, measuring approximately 387 miles from east to west and 276 miles from north to south, covering 104,247 square miles. Colorado is the eighth largest state and consists of mountains, plains, plateaus, and canyons. The eastern half of the state has flat, high plains and rolling prairies that gradually rise westward to the front range foothills and the higher ranges of the Rocky Mountains. The Continental Divide runs from north to south through west central Colorado and bisects the state into eastern and western slopes. The western half of the state consists of alpine terrain interspersed with wide valleys, rugged canyons, high plateaus and deep basins.

The state can be divided into five distinctive regions within its 64 counties: the Front Range, the Western Slope, the Eastern plains, the Eastern mountains, and the San Luis Valley. Each of these areas has grown in population, ranging from a 15 percent increase in the San Luis Valley from 1990 through 2000 to a 38 percent increase on the Western Slope. Close to 82 percent of the population lives in the Front Range, which includes the metropolitan areas of Denver-Boulder, Ft. Collins, Greeley, Colorado Springs, and Pueblo. The San Luis Valley in the southern part of the state is the region with the smallest population, with about 46,000 residents. Over fifteen percent of Colorado residents are considered rural residents, living outside core urban areas and areas adjacent to an urban core. Yet, close to 40 percent of these rural residents live in the urbanized Front Range counties. The rural vastness of much of the state is confirmed by 23 of Colorado's 63 counties in the 2000 Census qualifying as "frontier counties," containing fewer than 6 persons per square mile. The mountain range separating the populated Front Range from the more rural areas of the Western Slope, Eastern mountains, and San Luis Valley makes the delivery of health care more difficult to those in these rural areas.

In 2001, one additional county was added to the existing 63: Broomfield County consists of areas formerly in the urban counties of Adams, Boulder, Jefferson, and Weld. Each of the 64 counties within Colorado has its own local government. There are 15 organized health departments covering 24 counties. In addition, 39 county nursing services provide services to the remaining 40 counties.

Population

The population of Colorado is estimated at 4,647,321 in 2005, an increase of 346,060 since the 2000 Census enumerated the state's population at 4,301,261. Average annual growth in recent years has been 1.6 percent, down from the 2.7 rate of the 1990s, but high enough to make Colorado still one of the fastest growing states.

The two major racial and ethnic groups in Colorado are White non-Hispanic and Hispanic. In the 2000 Census, 74.5 percent of the population identified themselves as White non-Hispanic, 17.1 percent identified themselves as Hispanic, and 8.4 percent identified themselves as not Hispanic and not White. Among all racial groups (not considering Hispanic ethnicity which is generally included under White), 82.9 percent of the population was White; 3.8 percent was African-American or Black; 2.2 percent was Asian; 1.0 percent was American Indian; 0.1 percent was Native Hawaiian or Pacific Islander; 7.2 percent was some other race; and 2.8 percent were persons belonging to two or more racial groups.

The Hispanic population has grown rapidly in recent years; from 735,601 in 2000 to an estimated 876,800 in 2005. Much of the increase in the Hispanic population is made up of United States

citizens and immigrants who are in the United States legally, but some substantial but unknown amount of growth consists of undocumented workers and their families who are not legal residents.

The total number of births in Colorado has also increased rapidly in recent years. In 2000 there were 65,429 births, which grew to 69,305 in 2003. The number of deaths has changed as well over this time period. In 2000 there were 27,229 deaths which grew to 29,410 in 2003. It is important to note that migration has also been an important factor in the state's population growth in recent years. Between 2000 and 2005, net migration is estimated to have added an additional 195,000 residents.

According to the 2003 American Community Survey, the Census Bureau's most up-to-date annual survey, 15 percent of children and adults spoke a language other than English. For both children and adults, Spanish was the main other language spoken with 12 percent of school-aged children and 11 percent of adults able to speak Spanish. The survey estimated that from 3 to 5 percent of households in Colorado were linguistically isolated, i.e., that all members 14 years and older had at least some difficulty with English.

Estimates by the Colorado Department of Local Affairs suggest that almost 21 percent of the population in 2005 (992,490) are women of reproductive age (15-44). Approximately 29 percent or 1.3 million are children 19 and younger. The number of women of reproductive age is projected to grow by over 10 percent in the next ten years to close to 1.1 million; the number of children in the state is projected to grow by over 15 percent in that same time period to close to 1.5 million.

Economy

With the influx of population in the 1990s, Colorado experienced an increase of over 42 percent in employment growth from 1990 through 2003, making it the 5th highest state in employment growth during that time, much higher than the national average of 19 percent. Colorado saw record low unemployment in 2000, but the economy began a downturn in 2001. The years 2002 and 2003 were recession years for the state, and recovery, beginning in 2004, has been slow. The April 2005 unemployment rate stands at 5.2 percent, compared to 6.1 percent in July 2003 and a record low of 2.7 percent in 2000.

In 2003, 9.8 percent of the population in Colorado was estimated to be living below the poverty level; 11.5 percent of children 5 to 17 and 16.4 percent of children under 5. The poverty rate for the state's largest minority population, those of Hispanic origin, was estimated at 16 percent, and one in 5 Hispanic children age 0 to 17 lived in households below the poverty level. While the American Community Survey did not estimate the poverty rate for women of reproductive age by race and ethnicity, the 2000 Census reported that 21 percent of all Hispanic women of reproductive age lived below the poverty level.

Health Care Access

Colorado ranked 37th in the proportion of residents with health insurance coverage among all states in 2003. A total of 16.2 percent of all Colorado residents and 13.7 percent of Colorado's children were without health insurance in that year; Colorado's ranking for children with health insurance coverage was 43rd among all states. Furthermore, about one-quarter of women under the age of 35 are without insurance. About one-third of women giving birth each year receive coverage for prenatal care through Medicaid; this proportion has increased in recent years. About 1 in 6 children in the state are covered by Medicaid. In addition, the Colorado Child Health Plan Plus program covers about one in every 15 children in the state.

Community health centers (CHCs) are an important source of care for low-income residents, both

Medicaid-eligible, Child Health Plan Plus-eligible, and those who are uninsured or underinsured. However, CHCs are not available in all communities that have populations in need and lack sufficient capacity to meet the need in many communities where they do exist.

Many children or adolescents need some form of mental health care or counseling, but the majority do not receive help. Not only is access to care not assured, services are not available in many areas of the state.

Additionally, oral health access continues to be a challenge, especially for uninsured or children enrolled in Medicaid. Hispanic children, compared to White, non-Hispanic children, had a significantly higher proportion of existing dental caries and untreated decay. Less than one in six Hispanic third graders had dental sealants, half the level of White non-Hispanic children. About 75 percent of Coloradans on public water systems have access to fluoridated water, but well over half a million state residents do not drink fluoridated water. A full report, The Impact of Oral Disease on the Health of Coloradans, can be found at www.cdphe.state.co.us/pp/oralhealth/Impact.pdf.

Title V has in place systems to determine the importance, magnitude, value, and priority of competing factors impacting health services delivery in the state. State and local-level MCH staff are involved in priority setting and planning to meet these needs. The system is described in detail in Section II.

/2007/

Colorado's population continued to grow between 2005 and 2006, reaching an estimated 4,719,923 and continuing the 1.6 percent annual growth rate of the new decade. While the number of births in the state fell by 1.2 percent between 2003 and 2004, preliminary data for 2005 show a small increase between 2004 and 2005.

Unemployment figures this year show improvements below the final rate of 5.0 percent in 2005. In February 2006, the rate reached a low of 4.3 percent.

Colorado's ranking for health insurance coverage was 36th in 2004 (United Health Foundation, 2004), similar to the state ranking of 37th in 2003. The percentage of the population without insurance was 17.1--one in six persons.

The state's ranking on the percentage of children with health insurance was 46th, tied with Arizona (American Academy of Pediatrics, 2005). Only three states had lower (worse) rates: Florida, Nevada, and Texas. A total of 15.1 percent of children under 18 were without insurance in 2004--one in seven children in the state. //2007//

/2008/

Colorado's population is now approaching 5 million, with an estimate of 4,902,323 projected as of July 1, 2007. This number results from an average annual growth rate of 2.0 percent since 2000, when the population according to the Census was 4,301,261. The number of births in 2006 is estimated at 70,500, up from 2005, when they totaled 68,922, and a considerable increase since 2000, when they totaled 65,429. The total number of deaths in 2006 is estimated at 29,500. Annual net migration for the period 2006 to 2007 is estimated at 54,000, contributing more to growth in the state than the number due to natural increase (births minus deaths, or approximately 41,000).

Colorado's economy performed well in 2006, with an unemployment rate of 4.3 percent. In April 2007, the most recent month for which data were available at the time of this writing, the rate had fallen further to 3.4 percent.

Colorado's ranking for health insurance coverage improved slightly from 36th in 2004 to 35th in 2006 (United Health Foundation). The percentage of the population without insurance was 17.0--one in six persons. The Colorado Blue Ribbon Commission on Health Care Reform is presently studying a number of proposals to provide health coverage to more Coloradans.

The state's ranking for the percentage of children with health insurance inched up from 46th in 2005 to 44th in 2006 (American Academy of Pediatrics, September, 2006). Six states had lower (worse) rates of uninsurance: Arizona, California, Florida, Nevada, New Mexico, and Texas. A total of 13.5 percent of children under the age of 18 were without insurance in 2005--one in every seven children in the state according to the Academy.

Colorado's child immunization rates improved substantially according to the most recent figures. Colorado ranked last among the 50 states in 2002, when its immunization rate for children age 19-35 months was 56 percent. By 2005, Colorado had jumped to 16th place, with 79 percent of children fully immunized. //2008//

/2009/

In July 2008 Colorado's population reached the 5 million mark, with an estimated 5,008,259 residents. Births in 2007 totaled over 70,700; deaths totaled 29,800, and net migration was estimated at 65,000.

Colorado's economy has experienced increasing unemployment since this grant was written in the spring of 2007. The unemployment rate has been increasing since April 2007, and the February 2008 rate of 4.4 percent is the highest level seen since August 2006.

Colorado's ranking for health insurance coverage is 36th out of 50 states. A total of 17.2 percent of the population is uninsured.

The percentage of children who are without health insurance appears to be declining according to the Colorado Child Health Survey. Calendar year 2004 data showed a rate of 12.6 percent; 2003 data showed 11.9 percent, and 2004 data showed 10.2 percent without insurance. //2009//

/2010/
In July 2009 Colorado's population grew to an estimated 5,109,700. Births in 2008 were quite similar to the number in 2007, with 70,804 recorded. Deaths totaled 30,905, and net migration was estimated at 52,500, down some 12,500 from the previous year.

Colorado's economy continued to struggle, and unemployment in March 2009 reached 8.5 percent. While this level was below the national rate of 9.5 percent for the same month, the state rate was nearly double the rate cited above (4.4 percent in February 2008) and was the highest monthly rate since 7.7 percent was reached in May 1987, 22 years ago.

Colorado's ranking for health insurance coverage, according to the United Health Foundation, was unchanged at 36th in 2008 (only 14 states had lower rates of coverage). The Colorado Blue Ribbon Commission on Health Care Reform's recommendations, which provide a number of options to the health care crisis, were put on hold because of the state's budget shortfall and resulting cuts.

The percentage of children who are without health insurance is 8.2 percent according to the Colorado Child Health Survey for 2008. This is lower than the percentage reported last year (10.3 percent).

The impact of Colorado's poor economy and indicators of health in the next few years remains to be seen. However, the association between financial status and health status is robust, and the large-scale loss of jobs statewide may well contribute to some

deteriorating indicators in the immediate future. //2010//

B. Agency Capacity

The MCH Section works with other state health department divisions and programs to promote and protect the health of all mothers and children, including children with special health care needs. The State Overview, Section III A, describes the characteristics of Colorado's population and lays out some of the challenges currently facing the state. This section provides information on the state health department's capacity to carry out its mission. The following section, organized under four headings, describes the Health Care Program for Children with Special Needs (HCP).

HCP is contained within the Children and Youth with Special Health Care Needs Section, which was created in late 2003. (See III B attachment for organizational chart). Other components of the section are Genetics and Newborn Screening, the Medical Home Initiative, the Data Integration Program, and the Newborn Hearing Program. Activities within HCP that support local and state efforts are described below. The text also describes other programs that make up the infrastructure for HCP to carry out the six MCH national performance measures directed at children and youth with special health care needs.

1. State Program Collaboration with Other State Agencies and Private Organizations for Children with Special Health Care Needs

The Health Care Program for Children with Special Needs works closely with Part C Early Childhood Connections at the Colorado Department of Education to implement HCP care coordination standards, and to define respective roles in serving infants and toddlers with special health care needs. (The care coordination standards are also provided in the III B attachment). As a part of the collaboration, Part C staff are changing policies and procedures for serving infants in neonatal intensive care units. The HCP Program will be included in the initial referral process to help decide family medical and health needs and to determine the role of HCP in meeting those needs.

HCP is also beginning to use the care coordination standards in work with the Medicaid EPSDT Outreach program, thus helping to maximize EPSDT outreach services. The care coordination standards are also used with children receiving clinic services, the Colorado Responds to Children with Special Needs birth defects registry, and in the infant hearing screening followup.

The Medical Home Initiative, which began in 2000, is another example of state collaboration. The initiative is led by the Children and Youth with Special Needs Section and is designed to address the medical home national performance measure. The initiative consists of a state strategic planning group and the Medical Home Advisory Board. The Board includes staff from the state advocacy group, the University of Colorado Health Sciences Center, the Colorado Department of Education, mental health providers, health care financing experts, and pediatricians.

HCP works with JFK Partners, which is the Leadership Enhancement in Neurological Disabilities (LEND) grantee at the Health Sciences Center, to ensure that higher education and research are supporting Title V goals.

Public health genetics services, administered or supported by governmental agencies, require a unique kind of "buy-in" and support from nongovernmental and private sector partners. The sanction of activities in public health genetics is necessary because the public is fearful of a potential loss of privacy regarding health matters, and is wary of the potential for broad discrimination based on the misuse of genetic information. These issues are further exacerbated by a questioning of the government's role in this arena. To address these challenges, HCP calls on a diverse group of medical and public health professionals, scientists, policymakers, and consumers from all major organizations in Colorado that are involved in work in genetics. The

Colorado State Genetics Advisory Committee meets bimonthly to provide expert advice, review, and consultation to the state Genetics Program. The committee also ensures communication, coordination, and collaboration among the individuals and programs whose work in genetics may affect the public's health and right to privacy.

The HCP state family consultant works with a number of state agencies to establish relationships, develop memorandums of understanding, and to be available for technical assistance and follow up. Local implementation of the memorandums are facilitated by HCP's regional family coordinators who are members of HCP's multidisciplinary teams in all 14 regional offices.

/2007/In December 2005 the lead agency designation for Part C in Colorado was changed by the Governor's Executive Order. For 18 years the lead agency was the Department of Education. It is now the Department of Human Services, Division of Developmental Disabilities. The Children with Special Health Care Needs Section will continue to be represented on the state Interagency Coordinating Council and will promote their role in the Early Intervention system with the new state and local Part C personnel.

The Early Hearing Detection and Intervention grant is one of the programs in the Children and Youth with Special Health Care Needs Section. This project integrates newborn hearing, newborn metabolic screening and the Colorado Responds to Children with Special Needs birth defects registry data. The IT system began this spring and will de-duplicate records for more efficient follow-up, reducing duplicate contacts for families. The project has also developed database software for numerous agencies including the metabolic clinics at The Children's Hospital, the HCP program, and the Traumatic Brain Injury program. Future integrating of data sources for a more complete surveillance of children with special health care needs is planned.

The Colorado Medical Home Initiative has broadened its scope to assure a medical home approach for all children. The Medical Home Learning Collaborative is working with The Children's Hospital to increase the percentage of children enrolled in Medicaid and Child Health Plan Plus served in specific pediatric practices. Colorado is also combining the Medical Home Initiative with a state systems of care grant awarded through the Substance Abuse and Mental Health Services Administration. The Linking and Aligning Task Force is developing long and short-term plans. HCP is also beginning to link with The Children's Hospital oral health efforts to assure oral health is coordinated with primary care. //2007//

/2008/ CYSHCN staff worked with Part C and Children Adolescent and School Health staff to implement the Assuring Better Child Health and Development Project that will increase the use of standardized developmental screening in primary care practices. //2008//

/2009/ The structure of the Developmental Evaluation Clinic program, which had been partially supported by ECC for many years, changed to a HCP Specialty Clinic model.

The Unit continued work with the CDPHE Lab to increase effectiveness and efficiency of newborn screening and follow-up. An attempt was made to increase the screening fee so that The Children's Hospital contractors can increase their capacity to meet the increased demand that was created with Tandem Mass Spectrometry. It was not approved and a fee increase will be sought again next year.//2009//

/2010/ The Colorado Medical Home Initiative, led by the Title V CSHCN Unit, has continued to convene a broad array of stakeholders to improve the pediatric health care system while building the capacity of providers to use a Medical Home approach. A Colorado Medical Home website was developed along with a resource guidance for providers; a Family-Centered Care tool was piloted and a revised version of the Medical Home self-assessment tool was disseminated.

The Newborn Metabolic Screening program received additional federal funds to enhance

follow-up services.

The CSHCN Unit continued to work with Part C at the state level through an Interagency Agreement for Hearing Screening follow-up, health consultation and follow-up for infants in the Neonatal Intensive Care Units. //2010//

2. State Support for Communities for Children with Special Health Care Needs
The Health Care Program for Children with Special Needs program structure consists of a state office that supports all 64 counties in Colorado. Fourteen organized health departments serve as HCP regional offices for the other three smaller health departments and for the 39 county nursing services. All receive direct financial support through contracts with the state HCP office. With state office technical support, the 14 HCP regional offices provide administration and technical assistance to the small health departments and nursing agencies. This structure creates a strong network with personnel in every county of the state who are dedicated to serving children and youth with special health care needs. A map showing the regions is contained in the III B attachment.

Each regional office has a multi-disciplinary team of coordinators. Teams are made up of team leaders, parent/family coordinators, nurses, social workers, audiologists, speech pathologists, occupational therapists, physical therapists, vision coordinators, and nutritionists. The team provides support to the regional office, particularly in the areas of care coordination and infrastructure-building. The nurse care coordinator may delegate care coordination activities to another discipline, or seek consultation from another discipline to expedite the coordination of services. See the attachment for a description of the regional coordinator's scope of work.

Discipline coordinators have natural connections in communities that allow for the development of improved processes across agencies, as well as the ability to convene appropriate groups to address community needs. Each discipline coordinator on the team receives technical support through the state level same discipline consultant who is a state and sometimes a national leader in his field of study.

The state office also provides assistance with assessment, planning and evaluation for the regional offices. An electronic tool has been developed for local offices to help them with the planning process. Called HERMAN, HCP End of the Year Report and MCH Plan, this tool assures that attention is paid to the six national performance measures for children and youth with special health care needs. HCP also provides a state comparison of county/regional data to assist the regional offices in their planning efforts. Jefferson County's report is provided as an example at the end of the III B attachment. Finally, HCP has surveyed the regional offices to determine topics to pursue in the future through the learning community format.

/2007/Regional care coordination and community infrastructure efforts are documented in a newly designed database, called HCP Clinical Health Information and Records for Patients. The state office supports local staff by providing a Help Line, training, and enhancements to improve data collection associated with the database. The HCP End of the Year Report and MCH Plan have been updated and are more user-friendly and efficient. The Section's Data Analyst has enhanced the Section's ability to collect, manage and use data. //2007//

/2008/ The HCP local planning and reporting processes are being simplified. The HERMAN tool will be discontinued. //2008//

/2009/ A Medical Home Approach Action Guide was developed as a resource for local HCP programs. The guide encompasses the three services provided by all offices - care coordination, connection of primary and specialty care, and interagency collaboration. //2009//

/2010/ No changes to report. //2010//

3. Coordination with Health Components of Community-Based Systems for Children with Special Health Care Needs
Public health nurses and HCP's regional multidisciplinary teams work to assure that there is coordination at the local level among the services needed by families and children. Since HCP no longer provides direct care, local resources have shifted to providing care coordination services, population-based services, and to building public health infrastructure. All local HCP agencies provide resource and referral information regarding children and youth health services to the entire population. Each HCP agency provides care coordination services to targeted populations depending on community need, capacity, and reimbursement.

The Children and Youth with Special Health Care Needs Section employs a developmental pediatrician through the University of Colorado Health Sciences Center. The pediatrician works with the HCP Program and the University, training medical residents and providing public education to agencies, organizations and health care providers regarding diagnoses, the system of services, and HCP's public health role.

In the western part of the state, the Western Slope HCP regional office provides Level II and Level III care coordination in the community, assisted by state HCP office support. The Rocky Mountain Health Plan reimburses this work.

HCP provides consultation to community and regional teams for children with nutrition, feeding, and growth concerns. As a result, one Diagnostic and Evaluation Clinic has added a "feeding focus" with nutrition feeding assessments and diagnoses as part of the team's activities. This service is a collaborative effort with The Children's Hospital in Denver, local hospitals, the state health department, Early Intervention Services, the child's primary care provider, the regional developmental pediatrician, community therapists, and registered dietitians. Adding a feeding focus to additional Diagnostic and Evaluation Clinics is being evaluated.

HCP provides strong support to a statewide clinic system that is a coordination of local and state resources. HCP-sponsored clinic programs provide access to specialty medical care, genetic, and diagnostic and evaluation services. These clinics are important in assuring that families have access to specialized pediatric health services in rural and frontier areas of the state.

/2007/ No changes. //2007//

/2008/ No changes. //2008//

/2009/HCP rural specialty clinics continued to focus on existing priority issues in their communities. They also emphasize medical home components, particularly the coordination between specialists and primary care providers.

The Developmental Evaluation (D&E) clinic model was made more consistent with how other HCP rural specialty clinics operate. The ongoing need for medical developmental evaluations is being addressed with Early Childhood Connections, CHILD FIND and local primary care providers.//2009//

/2010/ Implementation of a HRSA Integrated Services grant helped to strengthen medical home infrastructure in two local communities.//2010//

The HCP Program used National CSHCN survey data as part of the MCH planning process. The Medical Home Action Guide was revised to reflect HCP care coordination and local systems building as the standard services to be delivered statewide. Care coordination was defined as having three levels; outcomes for care coordination were identified; and the process for collecting local evaluation data was designed.

The MCH Early Hearing Detection Initiative supported local teams in ten communities to improve the follow-up and referral into early intervention services. ***//2010//***

4. Coordination of Health Services with Other Services at the Community Level for Children with Special Health Care Needs
Since July 2004, the Colorado Department of Human Services has contracted with the HCP Program to provide care coordination through local offices to families of children with traumatic brain injury. The HCP Program was selected because it is the sole statewide entity with the children's services system in Colorado that can effectively connect health services with other services. Funding for this service is provided through a Traumatic Brain Injury Trust Fund created in 2002 supported by alcohol and speeding citations and fines.

Local HCP staff work closely with Part C coordinators to assure that health-related early intervention services are coordinated. Most local HCP staff are also involved in other interagency work such as serving on child protection teams, working with school districts to support parents in special education staffing, and developing Individual Education Plans or Individual Family Service Plans. HCP provides strong support to a statewide clinic system that is a coordination of local and state resources. HCP-sponsored clinic programs provide access to specialty medical care, genetic, and diagnostic and evaluation services. These clinics are important in assuring that families have access to specialized pediatric health services in rural and frontier areas of the state.

/2007/The HCP Traumatic Brain Injury Care Coordination Program was evaluated by external auditors regarding family satisfaction. Concurrently, an internal audit of ability to meet contractual obligations and quality assurance regarding services rendered were also completed. Chart audits and client surveys showed the program is very successful. This evaluation also helped to identify areas of needed development, such as the HCP care coordination role with the schools.

The Children with Special Health Care Needs Section has increased its emphasis on community development and partnerships with non-traditional partners. Examples include the Faith-Based Task Force, replication of community Respite Care Centers and community Transition Fairs. //2007//

/2008/ No Changes//2008//

/2009/ No Changes//2009//

/2010/ No Changes//2010//

State Statutes Relevant to Title V Programs
/2009/ Senate Bill 07-130 requires the Department of Health Care Policy and Financing (HCPF) to work collaboratively with the Colorado Medical Home Initiative (CMHI) to develop medical home practice standards and to increase the number of Medical Homes for children eligible for Medicaid and CHP+.

Senate Bill160, Concerning Improvements to Health Care for Children expands and simplifies health insurance coverage through Medicaid and the Child Health Plan Plus (CHP+) and raise CHP+ eligibility from 205 to 225 percent of the Federal Poverty Level (FPL). Eligibility can be expanded up to 250 percent of the FPL if additional funds are appropriated. The bill also expands the CHP+ mental health benefit so that it is equivalent to that found in Medicaid.

Senate Bill161, Concerning Eligibility for Public Medical Benefits, reduces barriers to enrollment in Medicaid and CHP+ for currently eligible children. SB161 eliminates the requirements for families to submit paycheck stubs and instead uses available data through the Department of

Labor and Employment (DOLE) to verify a family's income. DOLE data may also be used for reenrollment. It also directs an existing advisory committee to explore the feasibility of combining the Medicaid and CHP+ programs

Senate Bill 22, Concerning Over Expenditures in Children's Basic Health Plan, allows, with the governor's approval, expenditures of the Department of Health Care Policy and Financing to exceed their appropriations for the Children's Basic Health Plan.

The Autism and the Behavioral Health Commissions are identifying systemic barriers and best practices for the identification, treatment and coordination of services for these sub-populations of CSHCN. A budget request to fully fund the Colorado Immunization Information System was approved. //2009//

/2010/ Legislation was passed that created an Autism Commission.//2010//

Federal legislation has been introduced that will expand eligibility for Medicaid for family planning services. If this is passed, Colorado will not need to receive approval for its pending 1115 Medicaid Waiver and will be able to expand family planning services as proposed in the waiver application.

The Colorado Healthcare Affordability Act created a hospital provider fee that will generate an estimated $600 million in revenue. This revenue will be matched by the federal government, yielding a total of $1.2 billion that will allow Colorado to expand Medicaid to parents and single adults up to 100 percent of the federal poverty level (FPL), to expand CHP+ to children up to 250 percent of FPL, to create a Medicaid buy-in program for the disabled community, and to institute continuous 12-month enrollment. /***2010//***

State Title V Capacity to Provide a Variety of Services
A description of programs receiving some MCH funds that influence Title V's capacity to provide various services is provided below:

1. Preventive and Primary Care Services for Pregnant Women, Mothers and Infants
The Women's Health Section provides a small amount of funding for direct clinical prenatal care in communities where uninsured women would otherwise not be served. The Section's activities are primarily directed toward enabling- and population-based services for women, and are offered through organized health departments, community health centers, and local nursing services. Services include smoking cessation and nutrition counseling provided through the Medicaid-funded Prenatal Plus Program. Funding will cease for direct prenatal care beginning in FY 2006, due to reduced funding levels and the focus on more population-based services.

The Nurse Family Partnership Program provides intensive nurse home visitation to first-time low-income mothers during the prenatal period up to the child's second birthday. The Prenatal Plus Program provides case management services for high-risk Medicaid-eligible pregnant women. It is a Medicaid-funded program that provides case management, nutrition, and psychosocial services to pregnant women who are assessed to be at high risk for delivering low birth weight infants.

In 2000 the Women's Health Section released a report that showed that one of the contributing factors to the high rate of low birth weight infants in Colorado was inadequate weight gain among 25 percent of pregnant women. The report led to the initiation of a statewide campaign to promote adequate weight gain during pregnancy. The campaign uses social marketing techniques, targeted materials, training, and an informational website to reach out to prenatal care providers and consumers.

/2008/ The Women's Health Unit worked with the Diabetes Program to develop

comprehensive guidelines for the diagnosis and treatment of gestational diabetes and provided regional training. The Nurse Home Visitor Program is now part of this Unit. The message for the social marketing campaign regarding adequate prenatal weight gain was expanded to include prenatal smoking cessation. Additional projects include a multidisciplinary team approach to increase screening and treatment for postpartum depression and other mood disorders; and an Action Learning Lab for Smoking Cessation in Women of Reproductive Health Age. //2008//

/2009/ The Women's Health Unit continued to collaborate with the Diabetes Program to promote utilization of comprehensive clinical guidelines for the diagnosis and treatment of gestational diabetes and will provide technical assistance to healthcare providers. The Nurse Home Visitor Program and Prenatal Plus Programs engaged in planning to sponsor a joint statewide conference. A multidisciplinary team approach to increase screening and referral for postpartum depression and other mood disorders is being developed in the Prenatal Plus Program. The message for the Healthy Baby social marketing campaign emphasizes both appropriate prenatal weight gain and prenatal smoking cessation. An Action Guide was developed for use by local health agencies in implementing the campaign. Collaborative partnerships have been formalized externally through Colorado Clinical Guidelines Collaborative and within the department with a division project team to increase efforts to address prenatal smoking cessation.//2009//

/2010/ The Women's Health Unit completed the collaboration with the Diabetes Program to promote use of comprehensive clinical guidelines for the diagnosis and treatment of gestational diabetes by providing two well attended webinars, website resources, and technical assistance to health care providers. The Nurse Home Visitor Program and Prenatal Plus Programs sponsored a joint statewide conference. A multidisciplinary team approach to increase screening and referral for postpartum depression and other mood disorders was implemented by the Prenatal Plus Program. The message for the Healthy Baby social marketing campaign expanded to address appropriate prenatal weight gain and prenatal smoking cessation. Two Action Guides were developed for use by local health agencies in addressing the low birth weight rate and teen pregnancy prevention. Collaborative partnerships were formalized externally through the Colorado Clinical Guidelines Collaborative and within the department with a division project team to address prenatal smoking cessation. Work has begun to develop preconception care health promotion as a strategy to improve birth outcomes. //2010//

2. Preventive and Primary Care Services for Children/2007/
This section has been revised from last year's FY 2006 grant. The Child, Adolescent, and School Health (CASH) Section leads efforts to improve the health and well-being of all Colorado children and adolescents through health promotion, public health prevention programs and access to health care. The Section is comprised of both CASH-MCH team members and related programs that impact the child and adolescent population. The CASH-MCH team includes the Adolescent Health Program Director, the Early Childhood Program Director, the Nurse Consultant for School-Age Children, the School-Based Health Center/Coordinated School Health Director, and the Section Director. This team provides leadership in setting priorities; identifying and promoting best practices to address the priorities; and working with local public health, schools and other state and community partners to develop and implement comprehensive, coordinated strategies to improve the health of children and adolescents.

The Section administers a variety of state and federally funded programs to address the needs of children, teens and families. One is the Nurse-Family Partnership Program, implementing nurse home visits for first time low-income pregnant women and their children through the child's second birthday. Another is the Colorado Children's Trust Fund, with the mission of child abuse prevention and the support of the "Nurturing Parenting Program." The Family Resource Center Program supports resource centers in communities across the state to assist families with a variety of needs. The Tony Grampsas Youth Services Program supports local non-profit

organizations to prevent youth crime and violence, as well as child abuse. These funds support early childhood programs, student drop-out prevention programs, youth mentoring, restorative justice, after-school programs, as well as a variety of other programs targeting high-risk youth and families. Smart Start Colorado is a statewide alliance of early childhood partnerships working together to create a comprehensive system for young children birth to age eight and their families.

The School-Based Health Centers Program and the Colorado Association for School-Based Health Care convene, facilitate, and provide technical assistance to schools and provider agencies that develop, implement, and support school-based health centers. The Coordinated School Health Initiative is CDC-funded partnership to build state and local infrastructure to support the coordinated school health model, with an emphasis on nutrition, physical activity and tobacco prevention.

Advisory groups for the Section include the Advisory Council on Adolescent and the Youth Partnership for Health. The Advisory Council on Adolescent Health is an interdisciplinary group of adolescent health experts and community advocates, who advise the Colorado Department of Public Health and Environment, educate and inform the public, and advocate for policies and programs to improve the health and well-being of all Colorado adolescents. It includes inter- and intra-agency members. The Youth Partnership for Health is composed of 25 teens recruited from all areas of Colorado. The partnership advises the state health department on policies and programs that affect adolescents.

The Section works closely with other department programs: Injury and Suicide Prevention; Colorado Physical Activity and Nutrition; Immunizations; Interagency Prevention Systems; Women's Health; Tobacco; Children with Special Health Care Needs; Oral, Rural and Primary Care; Abstinence Education; Chronic Disease; and numerous other Departmental entities. Other efforts include close collaboration with the Department of Human Services (the Alcohol and Drug Abuse Division, Mental Health, Child Care, Youth Services and Child Protection); the Department of Transportation; the Department of Education (Coordinated School Health, school nursing, special education, early childhood and other prevention initiatives); the Department of Public Safety; the Cooperative Extension Program; higher education; and professional organizations such as the Rocky Mountain Chapter of the Society for Adolescent and the Colorado Chapter of the American Academy of Pediatrics. //2007//

/2008/ As part of a larger redesign of the Prevention Services Division, three programs have moved out of the Child, Adolescent and School Health Unit. The Colorado Children's Trust Fund and the Family Resource Center Program moved to the Injury, Suicide and Violence Prevention Unit. The Nurse-Family Partnership Program moved to the Women's Health Unit. The Child, Adolescent and School Health Unit continued to work with these programs.

The CASH and HCP Units are working to implement the Assuring Better Child Health and Development Project that focuses on promoting the use of standardized developmental screening tools in primary health care settings to help increase early identification of developmental concerns.

Colorado's new Lieutenant Governor has identified early childhood issues as a top priority and is committed to building on the work achieved through Smart Start Colorado and Colorado's Early Childhood Comprehensive Systems Grant from MCHB. To facilitate efforts, the Smart Start Colorado Director is now physically located within the Office of the Lieutenant Governor but is still a CDPHE employee. //2008//

/2009/Colorado is experiencing a period of increased interest and investment in school health. The School-Based Health Center Program, located within the Child, Adolescent and School Health (CASH) Unit, has received one million dollars from a private foundation to support school-based health centers throughout Colorado. In addition, another private foundation is supporting a

part-time technical assistance consultant, housed in the CASH Unit, to complete an assessment of technical assistance needs of school-based health centers. This assessment will help inform future public-private collaborations to support an effective technical assistance infrastructure for school-based health centers in Colorado. In addition to private foundation support, the Colorado state legislature increased school-based health center funding from $500,000 to one million dollars. Colorado has been awarded another five-year cycle of funding for the Coordinated School Health Program from the Centers for Disease Control and Prevention. A school health team, within the CASH Unit has been formed to maximize integration between the School-Based Health Center Program and the Coordinate School Health Program. //2009//

/2010/ The CASH Unit received a grant from The Colorado Trust to provide technical assistance to Colorado's 31 local early childhood councils. The technical assistance is associated with integrating health into local early childhood systems-building efforts. A staff person was hired to assist the local councils in the development and implementation of local health integration plans. //2010//

3. Services for Children with Special Health Care Needs
The Health Care Program for Children with Special Health Care (HCP), within the Children and Youth with Special Health Care Needs Section of the Colorado Department of Public Health and Environment, is responsible for building family-driven, sustainable systems of health services and supports for children and youth with special needs. Through interagency collaboration, the program connects families to culturally respectful, community-based resources. There are now 14 county-level offices statewide that assist families in obtaining needed care and services.

The Colorado Medical Home Initiative promotes a team-based approach to providing health care. Children and youth with special health care needs may have many professionals invested in their physical and emotional well-being. Coordination of care is an essential activity to assure communication and planning among team members, including family, primary health care practitioners, specialists, community programs, and insurance plans.

Colorado Responds to Children with Special Needs (CRCSN) is Colorado's birth defects monitoring and prevention program. CRCSN maintains a database with information about young children with birth defects, developmental disabilities, and risks for developmental delay. The program provides data to other programs, agencies, and researchers. CRCSN and HCP share data so that HCP can link children and families, who have been identified with birth defects and related disabilities, with early intervention services through the HCP CRSCN Notification program.

The Diagnostic and Evaluation (D&E) Program, also called the Diagnostic and Evaluation Clinics, provides access to comprehensive, multidisciplinary, developmental evaluation services for children who have or are suspected of having a developmental delay or disability. The program provides the needed medical diagnosis for many children who do not have access to a developmental pediatrician. It is community-based and coordinated with the Colorado Department of Education's Child Find and other local specialty providers. To ensure that D&E clinics are part of a child's medical home, training and consultation are provided to primary care physicians.

The Colorado State Genetics Program works to protect and improve the health of all Coloradans by promoting the availability of high quality, comprehensive genetic diagnostic, counseling, screening, treatment, and referral services.

The Newborn Screening Program provides screening at birth and again at 8 to 14 days of age for a variety of metabolic and genetic diseases for all infants born in the state. Presumptive positive screens are followed annually to make sure that affected infants are diagnosed and receive timely referral and treatment.

The Infant Hearing Program tests the hearing of infants at birth and identifies deaf and hearing-impaired infants and makes appropriate referrals. To support the program, a Colorado Infant

Hearing Advisory Committee was formed, comprised of parents, consumers, public health professionals, physicians, and other stakeholder state agencies. The advisory committee is very active, meeting quarterly, and supporting a variety of specific task forces that address issues and develop additional guidelines.

In Colorado, blind and disabled individuals under the age of 16 receive rehabilitation services under Title XVI (SSI). All SSI beneficiaries under 16 years of age are automatically eligible for Medicaid. Community-based EPSDT outreach workers call all newly enrolled SSI beneficiaries to assess whether each child's medical and support needs are being met. In the majority of cases, Medicaid is covering all of the medical needs. Staff of the Health Care Program for Children with Special Needs in the local health departments become involved when families have more complex medical or psychosocial needs needing care coordination.

In another effort, a durable medical equipment loaner bank is being developed. The state HCP occupational therapy/physical therapy consultant is building a statewide coordinated network to facilitate the development and expansion of a voluntary bank. Occupational and physical therapy coordinators have surveyed their regions for both the existence of and the need for loaner systems. A statewide Web site is planned for FY 2006 that will list inventory and conditions for accessing inventory. Parents and professionals will be able to list and locate inventory for use by a child or family.

The durable medical equipment loaner bank will be completely voluntary for all parties; none will incur responsibility as to the condition or fitting of equipment. Regional coordinators will be available to assist facilities or programs with the Web site and with initial inventory identification and entry. HCP staff plan to use volunteers, including high school and college students, in the effort to identify and inventory equipment. Satisfaction surveys will be used to measure the success of the system.

Family-centered, community-based, coordinated care including care coordination is another responsibility of the HCP program, which is engaged in a public education campaign to assure that all families of children with special health care needs know about the services that are available to them. This campaign also targets health care providers and partner agencies.

/2007/ A variety of updates regarding children and youth with special health care needs are provided in Section III B and Section IV C. //2007//

/2008/ The program's state and community level multi-disciplinary teams continued to move from a clinical-oriented system to one focused on medical home, screening and local health care systems of care development. This public health approach will assist the Unit in streamlining efforts to address needs given limited resources.

The CSHCN integrated data system was further developed. It has two applications 1) Newborn Evaluation, Screening and Tracking (NEST) and 2) Clinical Health Information and Records for Patients (CHIRP). The electronic newborn hearing screening system is now available and the newborn metabolic screening system will be available soon. The next steps include integration of the brain injury surveillance data.

An MCH grant that funded the state genetics program ended in March. The Metabolic Screening and Follow-Up Program received funding to develop a new state genetics plan that incorporated MCH and other areas.

A variety of updates regarding children and youth with special health care needs are provided in Section III B and Section IV C. //2008//

/2009/A variety of updates regarding children and youth with special health care needs are provided in Section III B and Section IV C. //2009//

/2010/ A variety of updates regarding children and youth with special health care needs are provided in Section III B and Section IV C. //2010//

4. Culturally Competent Care that is Appropriate to the State's MCH Population
In 2005, the Office of Health Disparities was established within the department, taking the place of the Turning Point Initiative. A Citizen's Commission on Minority Health was also initiated to coordinate the department's efforts in working with underserved communities.

2007/The department's Office of Health Disparities received an infusion of state funding. The Colorado General Assembly recognized that although Colorado as a whole is a healthy state, racial and ethnic minorities are disproportionately impacted by disease, injury, disability, and death. The Health Disparities Grant Program began distributing funds this year. The purpose of this grant program is to provide financial support for statewide initiatives that address prevention, early detection, and treatment of cancer and cardiovascular disease including diabetes or other precursors and pulmonary diseases in under represented populations. A total of $1,333,669 million was awarded for Fiscal Year 2005-2006. //2007//

/2008/ No changes to this area. //2008//

/2009/The CSHCN Unit working with the Colorado Developmental Disabilities Council will hold a conference on cultural competency in October 2008. The speakers are from the National Center for Cultural Competency at Georgetown University.//2009//

/2010/ The CSHCN Unit held a conference about cultural competency in October 2008 that featured Wendy Jones from the National Center for Cultural Competence. A follow-up meeting is scheduled next October. Women's Health is viewing and discussing all components of the Unnatural Causes series. The CASH Unit is hosting a Dimensions of Diversity learning circle to discuss social determinants of health and cultural competency. Staff members are participating in department initiatives to assess and address cultural competency including audio conferences and webinars on this subject.//2010//

Other Programs Supported by MCH funds
Child and maternal mortality reviews are done by a multi-disciplinary team working together to determine the underlying causes of maternal and child deaths. The reviews also promote preventive programs that may help reduce premature death. Multiple agencies and department programs are involved in both reviews.

The Family Healthline is the statewide MCH information and referral service. The Healthline resource specialist assists women, families, and individuals in locating free or low-cost health care services. Information is provided about other programs such as emergency shelters, food subsidies, or mental health. The Healthline specialists speak fluent Spanish and English. Special arrangements are made for hearing-impaired individuals.

/2009/ For an update on these programs, see Other Program Activities in Section 1V, part F. //2009//

/2010/ For an update on these programs, see Other Program Activities in Section 1V, part F. //2010//

C. Organizational Structure

The Colorado Department of Public Health and Environment is one of sixteen Colorado state agencies that are all located in Denver. Douglas Benevento, JD is the Executive Director, and

reports to Governor Bill Owens. A CDPHE organization chart is posted at http://10.1.0.61/ic/orgchart.pdf.

CDPHE consists of ten divisions. The Prevention Services Division is responsible for administering the MCH Block Grant, and the Division Director is Jillian Jacobellis, PhD. The Division administers eight sections: Nutrition Services; Chronic Disease; State Tobacco Education and Prevention Partnership; Oral, Rural and Primary Care; Women's Health; Child, Adolescent, and School Health; Children and Youth with Special Health Care Needs; and Injury and Suicide Prevention. The division houses a wealth of talent and resources relevant to women's and children's health, as well as expertise in health promotion and disease prevention. A division organizational chart is attached to this section.

/2007/ The Executive Director of the Colorado Department of Public Health and Environment is Dennis Ellis, who reports to Governor Bill Owens. //2007//

/2008/ A new governor, Bill Ritter assumed office in January 2007. The Governor appointed James Martin, an environmental attorney as the new Executive Director of the Colorado Department of Public Health and Environment. The new Lieutenant Governor Barbara O'Brien has a strong interest in the health of children and is expected to provide leadership in this area.

The Prevention Services Division (PSD), where MCH is housed, was re-designed in 2007. The redesign was driven by four internal reports, identifying strategic recommendations that, if implemented, would improve the capacity of the PSD to meet its critical public health responsibilities. The Division adopted the following goal to guide the redesign effort. "The Prevention Services Division is positioned to be a public health leader in producing healthy outcomes and reducing preventable death and disability by implementing best processes and practices that emphasize integrative, crosscutting approaches among prevention programs." Aligning structure and functions within the Division will be a critical component of realizing this vision.

The Division was divided into two Centers: The Center for Healthy Living & Chronic Disease Prevention and the Center for Healthy Families and Communities, along with an Office of Policy, Fiscal Analysis and Operations and a cross-divisional Epidemiology, Planning and Evaluation Unit. Two additional cross-divisional Training and Grants Management Units will be established in the coming year.

The Center for Healthy Families and Communities houses all MCH activities and is directed by Karen Trierweiler, MS, CNM, formerly the Director of the Office of Maternal and Child Health. Ms. Trierweiler also retains the role of MCH Director.

The Center for Healthy Families and Communities includes the Special Supplemental Nutrition Program for Women, Infants and Children; the Child and Adult Care Food Program housed with WIC; the Women's Health Unit (Family Planning, Prenatal, Prenatal Plus and Nurse Home Visitor Programs); the Child, Adolescent & School Health Unit (Early Childhood Systems Development, Adolescent Health Program, School-Based Health Centers, Coordinated School Health Program and the Tony Grampsas Youth Services Program); the Children with Special Health Care Needs Unit; the Injury, Suicide and Violence Prevention Unit; and the Center's Fiscal and Administrative Services Unit.

The Center for Healthy Living and Chronic Disease Prevention includes the Chronic Disease Prevention Branch (Diabetes; Cardiovascular Disease; Asthma; Comprehensive Cancer Program; Breast & Cervical Cancer Program, (Colorado Women's Cancer Control Initiative); the Oral Health Unit; the Healthy Living Branch that includes the Healthy Aging Unit, State Tobacco Education and Prevention Partnership, Colorado Obesity, Physical Activity and Nutrition Unit; and a Center-specific fiscal and administrative services Unit.

The Office of Policy, Fiscal Analysis and Operations includes the Interagency Prevention Systems for Children and Youth, which contains the Inter-Departmental Prevention Leadership Council; the Primary Care Office; and provides coordination of the Division's overall fiscal policy and human resources functions.

Reorganization of the Division has resulted in changes at the program level. Some staff have been moved from positions associated with specific programs to cross-divisional Units. For example, data and evaluation staff no longer report to the director of a particular program, but work together in the Epidemiology, Planning and Evaluation unit. As a result, program managers have access to a specific work unit composed of staff with a variety of skills in data and evaluation.

An updated organizational chart is attached to this section. //2008//

/2009/The Epidemiology, Planning, and Evaluation (EPE) Branch was operational. The Branch works collaboratively with programs in the Prevention Services Division and other partners to conduct systematic collection, analysis and interpretation of population-based and program-specific health and related data in order to assess the distribution and determinants of the health status and needs of the population, for the purpose of planning and implementing effective interventions, promoting policy development, and evaluating the outcome of these activities. The Branch provides accurate, timely, and valuable information and services that meet the needs of its partners.

An updated organizational chart is attached to this section.//2009//

/2010/ No large scale organizational changes occurred this year. An updated organizational chart is attached to this section. //2010//
An attachment is included in this section.

D. Other MCH Capacity

Title V funds and matching state funds pay for 47.7 FTE almost exclusively housed at the Colorado Department of Public Health and Environment in Denver.

The Office of Maternal and Child Health is directed by Joan Eden, RD, MS, and is composed of four units. A fiscal and contracts management section is led by Sally Merrow. The SSDI Coordinator, Jan Reimer, works with the MCH Epidemiologist, Bill Letson, MD, and a statistical analyst. Geoff Bock manages the MCH Data Services unit. Sue Ricketts, PhD is the MCH Demographer and is assisted by a statistical analyst.

Senior staff associated with MCH-priority area sections are Karen Trierweiler CNM, MS, Director of the Women's Health Section, Barbara Ritchen, RN, MS, Director of the Child, Adolescent, and School Health Section; and Kathy Watters, MA, Director of the Children and Youth with Special Health Care Needs Section. Organizational charts for the Office of Maternal and Child Health and the Prevention Services Division are attached.

There is one paid FTE family consultant within the Health Care Program for Children with Special Health Care Needs at the state health department in Denver. Each of the regional offices associated with the program has a family consultant.

Brief Biographical Information for Key MCH Management Staff

Joan Eden, RD, MS
Director of the Office of Maternal and Child Health and
Deputy Director of the Prevention Services Division

Joan Eden has a Master of Science Degree in Public Health and Nutrition from Columbia University. She is also a Registered Dietitian. Before coming to Colorado, she worked in New York City in a Maternal Infant Care Project as a clinical nutritionist. She has been with the state health department for 27 years working with the Migrant Health Program, the Prenatal Program, and the Child Health Program as a Nutrition Consultant. She served as the state's Children with Special Health Care Needs Director for eight years before becoming the state's Maternal and Child Health Director in October of 2000. She also serves as the Deputy Director of the Prevention Services Division.

Bill Letson MD, MS FAAP
Pediatric Consultant/Maternal Child Health Epidemiologist

Dr. Letson is trained in Pediatrics, Infectious Diseases and Public Health Epidemiology. He is from a Colorado Western Slope pioneer family and received his medical education at the University of Colorado. Dr. Letson's Pediatric and Chief Residency was completed at the University of Arizona. He completed a Pediatric Infectious Diseases fellowship at Johns Hopkins University, and additional Public Health Training at the Centers for Disease Control and Prevention, including a fellowship in Maternal Child Health Epidemiology. In addition to working for eight years on vaccine studies with CDC at Indian Health Service sites, Dr. Letson has practiced community pediatrics at clinics for uninsured children. He was also MCH director and Chief Medical Officer for the state of Wyoming.

Jan Reimer, BA
Coordinator, MCH State Systems Development Initiative (SSDI)

Jan Reimer has been the MCH State Systems Development Initiative Coordinator since 1993. Prior to this position she was the Coordinator of the Refugee Health Care Access Program for the State Health Department. Ms. Reimer was educated at Macalester College in St. Paul, Minnesota and holds a Bachelors of Arts in Sociology.

Sue Ricketts, M.A., PhD
Maternal and Child Health Demographer

Dr. Ricketts has been at the Colorado Department of Public Health and Environment for more than 20 years. She has long been involved in public health research in maternal and child health, particularly issues related to teen fertility, prenatal care, and low birth weight. Dr. Ricketts began her career at the Population Council in New York City, and came to Colorado to work at the former U.S. Department of Health, Education, and Welfare. She has also worked at the national Education Commission of the States in Denver and taught at Colorado Women's College and the University of Colorado at Denver. She holds an undergraduate degree in Economics from Wellesley College, and an M.A. and Ph.D. in Demography from the University of Pennsylvania.

Barbara Ritchen, RN, MA
Director, Child, Adolescent and School Health Section

Barbara Ritchen has been with the Colorado Department of Public Health and Environment since 1985, first as Director of the Adolescent Health Program, then of the Child, Adolescent and School Health Section. During that time she also directed a national center, funded by the federal Maternal and Child Health Bureau, to promote adolescent health leadership and to provide training and technical assistance to state MCH programs across the country. Her areas of expertise include child, adolescent and school health; training; team development; facilitation; leadership; health education and health promotion; community development; needs assessment

and strategic planning. Barbara's background includes a Bachelor of Science in Nursing from the University of Texas and a Master's Degree in Health Education from the University of Northern Colorado.

Karen Trierweiler, CNM, MS
Director Women's Health Section

Karen Trierweiler is a certified nurse midwife with over 25 years of experience in women's health as a clinician, educator, and public health professional. She received both her undergraduate and Master's degrees in Nursing from the University of Colorado. Ms. Trierweiler has worked at the Colorado Department of Public Health and Environment since 1990, originally as a nurse consultant, and since 2000, as the Director of the Women's Health Section.

Kathy Watters, MA
Director Children and Youth with Special Health Care Needs Section

Kathy Watters came to the Colorado Department of Public Health in 1984 from the Colorado Department of Education's State School for the Deaf and Blind. She received her undergraduate degree in Communication Disorders from the University of Cincinnati and her Master's degree in Audiology from the University of Colorado-Boulder. Kathy began her career at the state health department as the Home Intervention Program Director. She subsequently became the Hearing and Speech Director, the Consultation Team Director, the HCP Assistant Director, and the HCP Director. She is now the Section Director for Children and Youth with Special Health Care Needs.

MCH funds are distributed to local contractors (primarily health departments and nursing services) via a formal planning process. Based on the state-defined MCH priorities, contractors are asked to assess and prioritize the local health status needs of the perinatal, child and adolescent, and children with special health care needs populations; and to identify how their allocated MCH funds will be used. The services or activities they implement are expected to address the ten Colorado MCH priority areas.

The state-level MCH program assists agencies by providing consultation and technical assistance in developing and carrying out plans. Also, state-prepared model plans associated with priority areas are available. The plans consist of already developed goals, objectives, activities, process evaluation methods and outcome evaluation methods. Agencies can choose to implement one of these model plans or they may develop their own workplan. More information about the MCH planning process and forms are at www.cdphe.state.co.us/ps/mch/plan/forms.html.

/2007/Several changes have occurred among senior staff. Joan Eden retired and Karen Trierweiler is the new Director of the Office of Maternal and Child Health. Ms. Trierweiler was the Director of the Women's Health Section, and the acting director of that section is now Ms. Candace Grosz. Jan Reimer retired and the SSDI Coordinator is Helene Kent. Sue Ricketts, MCH Demographer, will be taking a phased in retirement and is working part-time.

Candace Grosz is Acting Director for Women's Health Section and the Program Manager for Prenatal Programs. She is a Licensed Clinical Social Worker (LCSW) with a master's degree in Social Work and previous experience in child abuse and neglect services, victim services and grants management. She currently provides supervision of prenatal and family planning programs, financial staff, and The Colorado Women's Cancer Control Initiative, and is also the program director for the Title X family planning program.

Helene Kent RD, MPH is the MCH Planning and Evaluation Specialist and will function as the

SSDI Coordinator. She has over 14 years of experience with the Colorado Department of Public Health and Environment, including previous tenure as the Director of the Women's Health Section within the Office of MCH. Ms. Kent was the Director of Assessment and Assurance for the Association of Maternal and Child Health in Washington DC.

An updated organizational chart is attached to this section. //2007//

/2008/Candace Grosz was appointed the Director of the Women's Health Unit.

Barbara Ritchen retired as the Director of the Children, Adolescent and School Health Section Unit.

Rachel Hutson has been appointed as the new Director of the Child, Adolescent and School Health Unit.

Ms. Hutson has been with the Colorado Department of Public Health and Environment since 2001, as the Director of Early Childhood Initiatives. She now provides supervision and oversight for Smart Start Colorado, the Coordinated School Health Program, the School-Based Health Center Program, the Child Health Program, Adolescent Health Program, and the Tony Grampsas Youth Services Program. Prior to working for the department she was the Pediatric Health Services Coordinator at the Colorado Coalition for the Homeless, where she provided primary health care services as a Pediatric Nurse Practitioner at the Stout Street Clinic in Denver. Ms. Hutson received a BA from Franklin and Marshall College and a Masters in Nursing from Yale University.

Bill Letson, MD left the Office of Maternal and Child Health.

Sally Merrow retired as the fiscal officer and has been replaced by Laurie Borgers.

An updated organizational chart is attached to this section. //2008//

/2009/
Gabriel Kaplan, M.P.A, Ph.D., is the branch director of Epidemiology, Planning and Evaluation. Dr. Kaplan recently joined the Department of Public Health and Environment after spending the last 5 years as an assistant professor of public policy at the University of Colorado, Denver School of Public Affairs. Dr. Kaplan received his Ph.D. in public policy from Harvard University in 2002 and his Masters in Public Affairs from Princeton University in 1994. He has worked as an analyst for the US Senate, for government agencies overseas, and nonprofit clients.

Laurie Freedle is the new fiscal officer.

Barbara Gabella is Epidemiolgy & Surveillance Director for the Epidemiology, Planning and Evaluation Branch.

Shirley Babler is the new Health Care Program for Special Needs Director within the Children with Special Health Care Needs Unit. //2009//

/2010/ Gina Febbraro, MPH was appointed the Maternal and Child Health Program Manager. Other center level MCH staffing has remained stable. //2010//

E. State Agency Coordination

Relationships among the State Human Service Agencies
MCH staff work with other state agency staff on a daily basis through numerous coalitions, task forces, advisory groups, committees, and cooperative agreements. The following text briefly describes a few key relationships.

An Interagency Prevention Council has existed for many years, and in 2000 was mandated through statute. The Council has created a more unified, effective and efficient approach to the delivery of state and federally-funded prevention, intervention and treatment services for children and youth in Colorado. More information can be found at www.cdphe.state.co.us/ps/ipsp.

The Colorado Department of Education is a close partner of the Title V program in supporting the coordinated school health model, school nurses across the state, and school-based health center activities. MCH has partnered with the Department of Education to support school health education, statewide conferences, adolescent health training, the Youth Risk Behavior Survey, and the Adolescent Health in Colorado Report.

The Colorado Department of Health Care Policy and Financing houses the Medicaid and children's health insurance plan for the state. The agencies work together to improve the health of Medicaid-eligible women and children and on issues such as EPSDT, lead poisoning, family planning, immunizations, birth defects, Prenatal Plus, and oral health.

The Colorado Department of Human Services (in particular the Division of Developmental Disabilities) is a close partner of Title V. There are ongoing interactions in the provision of services for the many children served by the Health Care Program for Children with Special Needs, children who are also eligible for services through the Colorado Department of Human Services. Programs include Early Intervention Services for child development for infants and toddlers birth to age three; Family Support Services Program for families who maintain a family member with developmental disabilities in the family home (all ages); Children's Extensive Support Waiver for children birth to 18 who are considered to be the most at-risk for out-of-home placement due to the severity of their needs; and the Children's Medical Waiver for children age birth to 18 with developmental disabilities that allows access to Medicaid state plan benefits for children who would otherwise be ineligible due to parental income. The state health department works closely with the Alcohol and Drug Abuse Division to plan coordinated workforce development and joint training and technical assistance. Other partners include the Division of Youth Corrections, the Mental Health Division, the Child Care Division, and the Child Protective Services Division.

Relationships with Federally Qualified Health Centers and Primary Care
The Colorado Community Health Network (CCHN) is the state primary care association representing 15 community, migrant, school-based, public housing, and homeless centers operating 108 health care delivery sites. Colorado's community health centers provide over 1.5 million visits to over 392,000 low-income patients each year, many of them women and children. Community health centers are the medical home for an estimated 28 percent of Colorado's low-income, uninsured population, 34 percent of Child Health Plan Plus enrollees, and 28 percent of Medicaid enrollees.

The Rural and Primary Care Office within the Oral, Rural and Primary Care Section works with CCHN to improve accessibility and expand primary care services to targeted low-income and vulnerable populations. These efforts include information and data sharing; recruitment and retention of health professionals; policy development; and assisting communities with applying for health professional shortage area and medically underserved designations.

Relationships with Local Public Health Agencies
The MCH program works through the state health department's Office of Local Liaison to address

MCH issues in the 39 counties with local nursing agencies. The MCH program works directly with the 15 organized health departments that serve the 25 largest counties in the state. MCH funds are distributed to local health agencies to assess the MCH population needs in their communities and to address priorities.

Relationships with Tertiary Care Facilities

MCH has a good working relationship with Denver Health, the largest community health system in the country. Denver Health includes Denver Health Medical Center, community health centers, school-based health centers, and the public health department for the city and county of Denver. The MCH program also works closely with The Children's Hospital, the state's only hospital for children. The Health Care Program for Children with Special Needs funds a position at the hospital to coordinate the inpatient and outpatient services provided through the hospital with those services needed and provided in the community.

Available Technical Resources

The Department of Preventive Medicine at the University of Colorado at Denver and Health Sciences Center provide technical resources to MCH programs. JFK Partners, a joint program between the Departments of Pediatrics and Psychiatry, is also another valuable resource. JFK Partners is the Leadership Enhancement in Neurological Disabilities grantee and focuses on children with developmental disabilities and special health care needs. The University of Colorado at Denver and Health Sciences Center School of Nursing and the Center for Human Investment Policy at the University of Denver also provide technical assistance on conducting community needs assessments; and provide legislative, policy, and research updates.

The Colorado Regional Institute for Health and Environmental Leadership housed at the University of Denver provides an Advanced Leadership Training Program for public health staff.

Colorado actively participates with other Title V directors and staff in planning initiatives associated with the MCHB-funded Rocky Mountain Public Health Education Consortium. Title V also encourages the participation of state and local-level MCH staff in the Rocky Mountain Public Health Education Consortium products such as the Summer Institute in Maternal and Child Health in Salt Lake City, the MCH Certificate program, and available distance learning courses.

Title V Program Coordination with other Specific Programs

The MCH Program works with many other programs within and external to the state health department. The following list is incomplete, but includes some programs not funded by Colorado Title V or other federal programs.

The Aurora Healthy Start Initiative is located in the city of Aurora, adjacent to Denver. The program developed in response to exceptionally high infant mortality in two zip code areas. MCH assists by providing demographic and health risk information for the two zip code areas, and by sharing materials and resources.

The Colorado Breastfeeding Task Force is a volunteer organization that works to ensure optimal health and development of mother infant bonding by increasing Colorado breastfeeding rates, particularly among underserved populations.

The Colorado Perinatal Care Council is a statewide organization of perinatal care providers. The Council's major focus is the coordination and improvement of perinatal care services in Colorado. The state health department provides space and support for the Council, which is co-located with the MCH program. The Council is a volunteer, non-profit, advisory group whose members include obstetricians, pediatricians, perinatologists, social workers, neonatologists, and nurse practitioners.

Colorado Covering Kids & Families (CKF) is a coalition-based project aimed at reducing the number of uninsured children. CKF has a membership of over 200 community-based organizations, agencies, and individuals. Through outreach efforts, CKF works to ensure that all eligible children and adults are enrolled in public health insurance programs.

The Folic Acid Task Force works to design and implement programs that will increase folic acid consumption among Colorado women by means such as targeted social marketing campaigns.

Healthy Child Care Colorado's goal is to provide safe and healthy child care environments; to increase accessibility to immunizations; and to provide access to quality health, dental, and developmental screenings and follow-up by supporting a network of child care health consultants. The initiative is an educational resource for center and family child care providers throughout the state. The project was previously funded through the Maternal and Child Health Bureau as part of the Healthy Child Care America initiative. When the funding ended in January 2005, the Child, Adolescent and School Health Section agreed to continue supporting the project through the MCH Block Grant.

Oral Health Awareness Colorado (OHAC!) is the statewide oral health coalition. The coalition has two primary goals: to maintain a media campaign ("Be a Smart Mouth"), and to develop a state oral health plan. The coalition is in the process of developing a statewide oral health improvement plan. The web address is www.beasmartmouth.com.

The State Tobacco Education and Prevention Partnership is funded from the state tobacco master settlement agreement monies. Goals include decreasing youth tobacco initiation; promoting quitting of tobacco among youth and adults; and reducing exposure to environmental tobacco smoke.

The Tony Grampsas Youth Services is a statutory program housed in the Child and Adolescent School Health Section. It provides funding to local organizations that target youth and their families with programs designed to reduce youth crime and violence. The program also focuses on funding programs that prevent or reduce child abuse and neglect.

/2007/The state health department's Child, Adolescent, and School Health Section, Colorado Physical Activity and Nutrition (COPAN) Program, and the WIC Program worked collaboratively with the Healthy Child Care Colorado Project, the Coordinated School Health Program, the Colorado Department of Education, and other interested state and local agencies and organizations in the past year. Together, they developed strategic state and local action steps to address the issue of overweight and obesity among children and adolescents. They have initiated an effort that will allow measurement of the heights and weights of children in kindergarten, first, second, third, seventh, and ninth grades in 50 randomly selected schools throughout the state. A similar collaboration is underway between COPAN and the Title X Family Planning Program. Clients have their BMI's assessed and receive appropriate weight management messages.

The state health department's Children and Youth with Special Health Care Needs Section is a co-sponsor with the Diabetes Program and the Child, Adolescent and School Health Section in establishing a Regional Diabetes Resource Nurse Program, along with the Colorado Department of Education, the Colorado Diabetes Advisory Council, and the Barbara Davis Center. The purpose of the program is to provide expert consultation to school nurses and school administration in all areas of the state about diabetes-related issues to insure optimal, standardized, and coordinated care for students with diabetes. The proposal, funding, training, and evaluation of the program were developed this year.

The Colorado Departments of Transportation; Revenue, Motor Vehicle Division; and Public Safety, State Patrol are key partners in new efforts to address teen motor vehicle safety.

The Colorado Department of Education works closely with early childhood state systems building efforts.

The Children, Adolescent and School Health Section, Nurse-Family Partnership Program is working with the Colorado Department of Health Care Policy and Financing to secure Medicaid reimbursement for targeted case management services, which will lead to an increase in the number of clients served.

The Colorado Department of Human Services, Alcohol and Drug Abuse Division works with the health department to develop a common Web based reporting and evaluation system for local grantees. //2007//

/2008/ MCH-funded programs continued to work closely with other partners to carry out activities. The Women's Health Unit has worked with the Diabetes Program and the state tobacco control program to initiate projects of joint interest. The Children and Youth with Special Health Care Needs and the Child, Adolescent, and School Health Units continue to work with many partners to carry out their respective work. Many staff are active members on committees and taskforces that have been convened to address common issues. Additional information regarding these activities is resented throughout this application. //2008//

/2009/ No changes to report. //2009//

/2010/ No changes to report. //2010//

Title V Program Coordination with Other Specific Programs
1. Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)
In 2003 after over 20 years of being responsible for case management and outreach portions of the Colorado EPSDT program, the state health department ceased administration of the program. The Medicaid Program now contracts directly with local health agencies. However, Health Care Program for Children with Special Needs local and regional care coordinators work with EPSDT staff on a daily basis. In almost every county health agency, the EPSDT coordinators work with other public health service programs such as WIC, prenatal, child health programs, immunization services, and the Health Care Program for Children with Special Needs. At the state level, Title V continues to work with EPSDT and to participate in the EPSDT State Advisory Board. EPSDT staff also serve on the Health Care Program for Children with Special Needs Medical Home Advisory Committee.

2. Other Federal Grant Programs
The WIC Program resides in the same division as the Office of Maternal and Child Health. Joint efforts for improving certain MCH performance measures have been in place for years. Current efforts are focused on increasing immunization and breastfeeding rates and decreasing childhood overweight. WIC funds go to all of the local health agencies.

Colorado is one of nineteen states that have received a CDC Coordinated School Health Program grant. The project's purpose is to build partnerships and an integrated, sustainable system that directly supports the missions of both the Colorado Department of Education and the Colorado Department of Public Health and Environment. Expected results are improved academic and health outcomes for Colorado school-aged children and youth.

An Early Childhood Comprehensive Systems Building grant is funded by the Maternal and Child Health Bureau. The initiative began in 2003 with a focus on creating a strategic plan to support a comprehensive early childhood system, which includes health, mental health, early care and education, family support and parent education. There are currently eight task forces working on the goal areas of Colorado's strategic plan: Program Quality and Standards, Program Availability,

Finance, Organizational Structure, Policy, Public Engagement, Parent and Family Engagement and Outcome and Evaluation. The two-year strategic planning grant ended June 30, 2005 and implementation funding through the Maternal and Child Health Bureau is anticipated in the fall of 2005.

Title X Family Planning is housed within the Women's Health Section, which also administers the prenatal component of the MCH Block Grant. The MCH Block grant and Title X family planning activities are well-integrated. Activities to address unintended pregnancy and teen fertility are targeted to both family planning and MCH contractors. MCH funds are not used to fund direct family planning services, but rather to support population-based activities around family planning and unintended pregnancy prevention.

The Child and Adult Care Food Program is a USDA funded program that provides reimbursement for nutritious meals and snacks served to eligible children in child care centers, family day care homes, and eligible adults in adult care centers. Work has been coordinated regarding healthy child care initiatives.

The Colorado Physical Activity and Nutrition Program (COPAN) is funded by CDC. The program developed and is implementing the Colorado Physical Activity and Nutrition State Plan 2010. The plan promotes healthy eating and physical activity to successfully prevent and reduce overweight, obesity, and related chronic diseases. MCH staff serve on the early childhood and school site task forces, planning joint videoconferences and tool kits.

Early Hearing Detection and Intervention (EHDI) is funded by a CDC grant. The grant allows for the integration of a variety of databases beginning with the universal newborn metabolic screening and infant hearing screening data. It will include the Birth Defects Monitoring Program, an immunization registry, and asthma surveillance data. Clinical databases have been created for Sickle Cell Disease, the Inherited Metabolic Diseases, and infant hearing loss. Work has begun on the central processing database and its linkage to the recently created databases and the Integrated Registration and Information System (IRIS). Also underway is the implementation of the CHIRP/NEST (Clinical Health Information Record of Patients/ Newborn Evaluation Screening and Tracking) applications.

Violence reduction efforts are funded by CDC. Colorado is one of eight states to receive CDC funding for a two-year program that will work to support change in societal norms and environmental conditions contributing to violence. A strategic plan is being developed that addresses shared risk and protective factors for violence among children and youth.

/2007/Colorado received a grant from the Maternal and Child Health Bureau, State Agency Partnerships for Promoting Child and Adolescent Mental Health, referred to as Colorado LINKS (Linking Interagency Networks for Kids' Services) for Mental Health. The mission of this initiative is to promote partnerships among state agencies and key stakeholder organizations by weaving together existing efforts to create a more coordinated continuum of mental health services for Colorado children, youth, and families.

Colorado received a $2,350,965 grant from the Substance Abuse and Mental Health Services Administration to advance community-based programs for substance abuse prevention, mental health promotion and mental illness prevention. The program, which is housed in the Alcohol and Drug Abuse Division (ADAD) at the Colorado Department of Human Services, is a collaborative effort between ADAD and the statewide Prevention Leadership Council. The purpose of this "Colorado Prevention Partners" grant is to build capacity and infrastructure at the state and community levels, reduce substance abuse-related problems in communities, and prevent the onset and reduce the progression of substance abuse, including underage drinking. The grant will bring together multiple funding streams from multiple sources in Colorado to implement a comprehensive approach to prevention that cuts across existing programs and systems.

Early Childhood Comprehensive Systems Building grant staff completed a two-year strategic planning process and received implementation funding from the Maternal and Child Health Bureau.

Colorado is one of two to receive CDC funding for implementation of a strategic plan that addresses shared risk and protective factors for violence among children and youth. //2007//

/2008/ No new grants were received this year. //2008//

/2009/ The Maternal and Child Health Integrated Systems for Children with Special Health Care Needs (CSHCN) proposal was selected for funding. The grant will support the goals of the Colorado Medical Home Initiative.

The MCH Early Hearing Detection and Intervention (EHDI) grant was awarded in March. This grant continues to support the Colorado Medical Home Initiative by ensuring the integration of the newborn hearing screening into medical home systems.

A CDC EHDI grant was awarded to integrated EHDI information technology systems with the states' immunization registry and Colorado's Early Intervention data system in the Department of Human Services. //2009//

/2010/ In June 2009 CSHCN received a three-year HRSA, State Implementation: Integrated Services for Children with Special Health Care Needs grant.

The Women's Health Unit was selected by a private donor to receive three to five years of funding as part of the Colorado Family Planning Initiative. Funding will be used to expand family planning services and provide long acting reversible contraception to decrease unintended pregnancies.

The CASH Unit received a Colorado Trust Foundation grant to provide technical assistance to local early childhood councils related to efforts to integrate health into their local early childhood systems building efforts. //2010//

3. Providers of services to identify pregnant women and infants who are eligible for Title XIX and to assist them in applying for other services.
The majority of local MCH contractors also served as presumptive eligibility sites for Medicaid. The Baby Care/Kids Care Program (authorized under Colorado's Medicaid state plan) allowed Medicaid presumptive eligibility determinations to be made at public health sites. MCH contractors identified women and infants who were eligible for Medicaid at the local public health site (through WIC, family planning, EPSDT, etc.), and deemed them presumptively eligible for Medicaid if the income requirements were met. With the elimination of the presumptive eligibility program, local sites are now assisting clients in completing Medicaid applications and working with both state and local social service providers to expedite eligibility determinations. Women are then referred to community resources for direct care, case management, and other services. Eligibility determinations are also made for Child Health Plan Plus in many of these same sites. Presumptive eligibility determination is expected to be reinstated in the coming year.

4. Title V Coordination with the Social Security Administration, State Disabilities Determination Services unit, Vocational Rehabilitation, and Family Leadership and Support Programs
Social Security Administration (SSA)

Relationships with the State Determination Unit of the Social Security Administration are strong. Local level EPSDT outreach workers make calls to families of children receiving SSI to assess whether service and support needs are being met. Referrals are made to the Health Care

Program for Children with Special Needs when family needs are complex and the EPSDT outreach worker feels that care coordination by a Health Care Program for Children with Special Needs staff member is appropriate.

Developmental Disabilities
This area was addressed in the Colorado Department of Human Services section under Relationships among the State Human Services Agencies.

Vocational Rehabilitation
Relationships with Vocational Rehabilitation have been cultivated through the Colorado Interagency Transition Team. This team of ten stakeholders collaboratively addresses the topic of youth transition to adulthood for the state of Colorado. In 2005, the state health department was invited to participate on the team with HCP as the representative. Also, a representative from Vocational Rehabilitation sits on the Colorado Health Transition Coalition, initiated and led by HCP. Both the Department of Education's Special Education Section and Vocational Rehabilitation are actively involved in the Brain Injury Steering Committee and a task force on Assistive Technology.

Family Leadership and Support
Title V has supported Family Voices Colorado financially and through membership on its board of directors since it became an official chapter in 2001. Family Voices is involved in the Medical Home Learning Collaborative. Family Voices also works with the state-level Children and Youth with Special Health Care Needs family position and local family consultants to implement the Family-to-Family Health Information Network, and provides state level family advocacy. The Health Care Program for Children with Special Needs has also financially supported the Colorado Families for Hands & Voices to engage in family advocacy, outreach to underserved populations, and parent leadership activities in our EHDI systems grant.

A number of examples of state agency coordination have been provided in this section, but this list does not contain every cooperative effort. Other examples are provided in the text in other sections, particularly in the performance measures sections (IV C and IV D).

/2007/ Family Voices also provides the parent perspective in developing systems of care for the Early Childhood State Systems Team. //2007//

/2008/There are no additions to this area at this time. //2008//

/2009/ The Colorado legislature initiated an interim committee, the Behavioral Health Taskforce, for the study of behavioral health and treatment in Colorado. The taskforce, composed of legislators, state agency staff and advocates, was charged with studying mental health and substance abuse services to coordinate state agency efforts, streamline service provision and maximize federal and other funding sources. A number of recommendations were developed by the task force and are available at http://www.csi-policy.org/1050taskforce/index.htm. As a result of this work, Governor Ritter convened a behavioral health cabinet, whose members are currently working on streamlined systems and integrated funding for behavioral health. //2009//

/2010/ No changes to report. //2010//

F. Health Systems Capacity Indicators

Introduction

The data for a variety of Health Systems Capacity Indicators for Colorado are shown below, along with a brief narrative for each topic. Funding from the MCHB SSDI grant helps to support the data

gathering and analysis activities associated with this section.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	63.2	65.9	57.7	53.8	46.4
Numerator	2089	2213	2002	1889	1646
Denominator	330533	335973	347145	350943	354990
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data shown for reporting year 2008 are calendar year 2007 data.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data.

Notes - 2006
Data shown for reporting year 2006 are calendar year 2005 data.

Narrative:
Health System Capacity Indicator 01 shows a variable rate of hospitalization for asthma, ranging between 46.4 and 65.9 per 10,000 children under the age of 5. Data for reporting year 2008 (2007 calendar year) show 1,646 hospitalizations, a rate of 46.4, the lowest rate in the five years shown.

The Colorado Child Health Survey, carried out annually, provides a wealth of data on asthma that contributes to an understanding of asthma beyond what hospitalization data can provide. According to the calendar 2007 survey (which pertains to the same time period as the data shown above for reporting year 2008) 11.9 percent of children ages 2 to 14 were diagnosed with asthma. Among this group, 77.3 percent still had asthma, 6.6 percent were hospitalized for asthma at least once in their lifetime, 20.3 percent had been to an emergency room or urgent care center for asthma, and 75.3 percent used a rescue medication. Among those who used a rescue medication, 50.8 percent carried an inhaler to school. Other information on asthma management plans is also available from the survey.

The Child Health Survey has been in place since 2004. With five years of data now available (calendar 2004 through calendar 2008), we can begin to look at trends and begin to have enough surveys to provide data for some large counties. Statewide, the percent of children diagnosed with asthma was 12.4 in 2004, 10.9 in 2005, 12.5 in 2006, 11.9 in 2007, and 10.0 in 2008. The year to year changes are not statistically significant and the rate is essentially unchanging. However, the most recent hospitalization rate of 46.4 is the lowest rate not only for the five years shown, but the lowest rate in ten years (calendar 1997 through calendar 2007).

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	84.2	80.3	94.1	89.6	92.0
Numerator	24554	25588	28344	26673	27998
Denominator	29171	31864	30122	29755	30438
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data for reporting year 2008 are from the HCFA 416 report for federal fiscal year 2008.

Notes - 2007
Data are from the HCFA 416 report for federal fiscal year 2007.

Notes - 2006
Data are from the HCFA 416 report for federal fiscal year 2006.

Narrative:
The percent of Medicaid enrollees under the age of one who received at least one initial periodic screen has varied considerably in recent years. Data are taken from the Medicaid CMS 416 form, but there appear to have been differences in how the infants were counted in different years, and the series may not contain consistent values.

The number of infants on Medicaid increased between reporting year 2004 (FY 04 data) and reporting year 2005 (FY 05 data), but declined in reporting year 2006 (FY 06 data) and 2007 (FY 07 data). Data for reporting year 2008 (FY 08) showed an increase to 30,438, higher than the previous two years but still lower than reporting year 2005 (FY 05). The introduction of the Colorado Benefits Management System (CBMS) in the fall of 2004 and new restrictions around required documentation of citizenship in July 2006 may have contributed to declines in the number of children served in certain years.

The percentage of infants on Medicaid who received at least one initial periodic screen increased to 92.0 percent in reporting year 2008 (FY 08). This percentage appears to be the highest achieved since reporting year 2006.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	0	0	73.9	0	49.0
Numerator			965		3979
Denominator			1305		8126

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final

Notes - 2008
Data for reporting year 2008 represents state fiscal year 2008 (July 2007 through June 2008). Children are enrolled in either a state managed care network or a health maintenance organization but tracking between systems is not possible. Consequently, there is some duplication in the reported numerator and denominator.

Notes - 2007
Data are not available for the period July 2006 through June 2007.

Notes - 2006
Data are for the period July 2005 through June 2006.

Narrative:
The Colorado Department of Public Health and Environment obtains data for this measure from the Colorado Department of Health Care Policy and Financing. In previous years the data were often not available. Data for reporting year 2008 were derived from combining counts of children served in two different systems under the Child Health Plan Plus program: the CHP+ state managed care network and the CHP+ health maintenance organization.

There may be some duplication in the counts of children in the overall CHP+ program as well as some duplication in the number receiving at least one periodic screen, since children cannot be tracked between the two systems.

The average length of coverage on the state managed care network was four months and for the HMO it was six months. Since the well-child visit schedule for infants recommends visits at 3-5 days, 1, 2, 4, 6, 9, and 12 months, every child in either system should have had at least one periodic screen. The data for reporting year 2008 show just half (49.0 percent) of children receiving screenings.

The Colorado Department of Health Care Policy and Financing is expected to continue to provide data for this measure in future years.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	67.1	76.6	76.1	74.0	67.0
Numerator	46500	51193	50881	50889	45976
Denominator	69304	66846	66903	68739	68635
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data shown for reporting year 2008 are calendar year 2007 data. The Colorado birth certificate was revised in 2007 so that prenatal care is based on medical records rather than self-report. This change yields a lower rate.

Notes - 2007
The data shown for reporting year 2007 are calendar year 2006 data. The denominator is less than the total number of resident births due to missing data needed for the Kotelchuck Index.

Notes - 2006
The data shown for reporting year 2006 are calendar year 2005 data. The denominator is less than the total number of resident births due to missing data needed for the Kotelchuck Index.

Narrative:
Data for reporting year 2008 are taken from the revised 2007 birth certificate. The percentage of women who received adequate care according to the Kotelchuck Index was 67.0 percent, the lowest value shown in the series.

Two out of three women in reporting year 2008 received adequate care; one out of three did not according to this measure. In most recent years three out of four had been reported to receive adequate care. While a decline in those receiving care may be due to changes in data collection methods, other measures of care support the general conclusion that fewer women are receiving adequate care currently.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	76.9	95.1	76.0	86.5	81.6
Numerator	260497	340929	237200	266888	210695
Denominator	338919	358435	312107	308431	258298
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data represent children ages 0 through 18 during 2005-2007. Data are available in the Colorado Children's Health Insurance 2009 Update Issue Brief at http://www.coloradohealthinstitute.org/Documents/sn/EBNE.pdf.
These data were derived from an improved methodology for estimating children eligible for Medicaid.

Notes - 2007

Date reported in previous years were based on an estimate. Current data reported reflects actual data for calendar year 2006. The numerator is the number of children enrolled in Medicaid vs. the number of potentially Medicaid-eligible children.

Notes - 2006
The number of potentially Medicaid-eligible children who have received a service paid for by the Medicaid program is estimated to be 76.0 percent of all enrolled/eligible children. The estimate is based on a review of all Medicaid utilization data for calendar 2006 for children age 1 through 19. The method for estimating the percentage receiving at least one service is substantially improved from methods used for reporting years 2005 and earlier.

Narrative:
An estimated 81.6 percent of children who were eligible for Medicaid in Colorado were enrolled in the program. The data shown for reporting year 2008 come from a new in-depth study done by the Colorado Health Institute in the spring of 2009 using data from 2005 to 2007. The U.S. Census Bureau's Current Population Survey, used as the basis for the study, is carried out annually among 4,000 Colorado households in March each year.

The percentage shown is the total number of children in the Medicaid program compared to the total number eligible for the program. While about 8 in 10 children are enrolled in the program, the data shown do not indicate the number within the program who received a service. Because data on the number of Medicaid -eligible children who received a service paid by the Medicaid program is not available, the percentage of total number of children in the Medicaid program compared to the total number eligible for the program is used as a proxy for this specific capacity indicator.

The full report can be seen at http://www.coloradohealthinstitute.org/documents/sn/EBNE.pdf.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	45.3	63.2	49.9	51.5	53.8
Numerator	24751	46987	32794	34303	37126
Denominator	54590	74333	65757	66603	68974
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data are from the HCFA 416 report for federal fiscal year 2008.

Notes - 2007
Data are from the HCFA 416 report for federal fiscal year 2007.

Notes - 2006
Data are from the HCFA 416 report for federal fiscal year 2006.

Narrative:
The percentage of EPSDT eligible children age 6 through 9 who have received any dental services during the year increased sharply between reporting years 2004 and 2005, and then fell in reporting year 2006 (federal fiscal year 2006). There have been changes in how the Centers for Medicare and Medicaid calculate this statistic, but the value of 49.9 percent (reporting year 2006) is considered to be a more accurate representation of the percent of EPSDT children receiving services than figures prior to 2004. Since reporting year 2006, the percentage of children receiving dental services appears to have increased slightly, reaching 53.8 percent in reporting year 2008 (federal fiscal year 2008). It is worth noting, however, that the number of children age 6 to 9 in the program has declined since reporting year 2005.

This health systems capacity measure is Colorado's State Performance Measure 2. For futher explanation of this measure, please refer to the discussion in Section IV D of the grant.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	5741	5940	6133	7495	6702
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Since July 1, 2003, Colorado Children with Special Health Care Needs Program does not directly provide rehabilitative services to state SSI beneficiaries.

Denominator data are from the Social Security Administration and pertain to 2008. The numerator of zero is correct.

Notes - 2007
Since July 1, 2003, Colorado Children with Special Health Care Needs Program does not directly provide rehabilitative serices to state SSI beneficiaries.

Denominator data are from the Social Security Administration and pertain to 2007. The numerator of zero is correct.

Notes - 2006
Since July 1, 2003, Colorado Children with Special Health Care Needs Program does not directly provide rehabilitative serices to state SSI beneficiaries.

Denominator data are from the Social Security Administration and pertain to 2006.

Narrative:

The state Children with Special Health Care Needs program stopped paying for rehabilitative services in July 2003. Therefore, 0 percent of state SSI beneficiaries less than 16 years old have received rehabilitative services from the program in all reporting years since then.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2007	other	9.7	8.6	9

Notes - 2010
Data for reporting year 2008 are from the revised 2007 Colorado birth certificates. Medicaid status on the payment status for each birth is now being collected. Data shown for reporting years before 2008 were based on PRAMS (Pregnancy Risk Assessment Monitoring System) survey data.

Narrative:
Birth certificate data for women covered by Medicaid is available for the first time for calendar year 2007. Data for previous years was reported using Pregnancy Risk Assessment Monitoring System (PRAMS) data.

Medicaid women are at an increased risk of having a low birth weight infant (9.7 percent vs. 8.6 percent). The Medicaid rate is nearly a full percentage point higher than the non-Medicaid rate.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2007	other	6.1	6.1	6.1

Notes - 2010
The state rate for infant mortality was 6.1 deaths per 1,000 births in 2007. This value has been entered as an estimate for both Medicaid and non-Medicaid populations.

Medicaid and non-Medicaid infant mortality rates will be available in grant applications for FY 2011 and later. Medicaid status was added to the birth certificate in 2007; infant mortality rates for 2007 wil be calculated after the end of 2008.

Narrative:
Infant death data by Medicaid and non-Medicaid status are not yet available. Birth certificate data for the year 2007 forward contains an identifier for Medicaid births, but the linked file of infant deaths from 2007 births was not available at the time this grant was submitted.

The 6.1 rate shown is an estimate for both Medicaid and non-Medicaid births; the Medicaid rate is expected to be higher than the non-Medicaid rate when final data are available.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	other	66.4	84.2	78.1

Notes - 2010
Data for reporting year 2008 are from the revised 2007 Colorado birth certificates. Medicaid status was added to the birth certificate in 2007. Data shown for reporting years before 2008 were based on PRAMS (Pregnancy Risk Assessment Monitoring System) survey data.

Narrative:
The data shown are from the revised 2007 birth certificates, which contain data on Medicaid status for the first time. Medicaid clients enter prenatal care at much later dates than non-Medicaid patients; two out of three begin care in the first trimester compared to 85 percent of non-Medicaid patients beginning care early.

The challenge for Colorado is clearly among women whose prenatal care is covered by Medicaid. Numerous obstacles exist for early care for this group, including the application process.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to	2007	other	63.5	68.9	67

expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])					

Notes - 2010
Data for reporting year 2008 are from the revised 2007 Colorado birth certificates. Medicaid status was added to the birth certificate in 2007. Data shown for reporting years before 2008 were based on PRAMS (Pregnancy Risk Assessment Monitoring System) survey data.

Narrative:
The data shown are from the 2007 birth certificates which contain data on births to women on Medicaid for the first time.

This measure reveals that just two-thirds of all Colorado women receive appropriate care according to the Kotelchuck Index. There is a five-point difference between Medicaid and non-Medicaid women, revealing an even greater difficulty among Medicaid women to meet the Kotelchuck standard. Nonetheless, women who are not on Medicaid appear to fall well short of the standard as well.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	205

Notes - 2010
Data for reporting year 2008 are from http://cchn.org/ckf/resources.php.

Notes - 2010
Data for reporting year 2008 are from http://cchn.org/ckf/resources.php.

Narrative:
The percent of poverty level for eligibility for infants in Colorado's Medicaid plan is 133 percent, while the level for infants in the Child Health Plan Plus Program rose to 205 percent in April 2008.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2008	 133 100

INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2008	205

Notes - 2010
Data for reporting year 2008 are from http://cchn.org/ckf/resources.php.

Notes - 2010
Data for reporting year 2008 are from http://cchn.org/ckf/resources.php.

Narrative:
Important changes in both the Medicaid program and the state Child Health Plan Plus program occurred in 2005. The Medicaid program removed the assets test, which had prevented many children from receiving Medicaid benefits. The test had limited a family to $2,000 in assets, although the test did not apply to pregnant women or to children under 1. Removal of the assests tests requirement began in July 2006.

/2009/
Presumptive eligibility for children in CHP+ and Medicaid was implemented in January 2008. This change provides children and pregnant women at least 45 days and up to 60 days of immediate coverage as they await final eligibility determination.

The 2008 state legislature increased the federal poverty guideline for the Child Health Plan Plus program to 205 percent effective April 2008.

Effective July 2008, the poverty level for determining Medicaid eligibility for children ages 6 to 18 increased from 100 percent to 133 percent of the poverty level.

Effective March 2009, CHP+ eligibility will increase to 225 percent of the poverty level for children.

Further discussion of these changes can be found in Section IV C, National Performance Measure 13. //2009//

/2010/
Because of budget constraints, CHP+ eligibility was not increased from 205 to 225 percent of poverty in March 2009 as had been planned, nor is it expected to increase in the following fiscal year. //2010//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2008	133
INDICATOR #06	**YEAR**	**PERCENT OF**

The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.		POVERTY LEVEL SCHIP
Pregnant Women	2008	205

Notes - 2010
Data for reporting year 2008 are from http://cchn.org/ckf/resources.php.

Notes - 2010
Data for reporting year 2008 are from http://cchn.org/ckf/resources.php.

Narrative:
Presumptive eligibility for children in CHP+ and Medicaid was implemented in January 2008. This change provides children and pregnant women at least 45 days and up to 60 days of immediate coverage as they await final eligibility determination.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010

Narrative:
The Prevention Services Division is able to obtain data from most of the data sources listed, and has access to the electronic databases. The Health Statistics Section at the state health department provides much of the data and much of the analysis in addition to the analytical work by the staff of the Epidemiology, Planning and Evaluation Branch in the Prevention Services Division.

However, use of the hospital discharge survey data, other than for injury analysis, is limited. More staff resources are needed to make use of the information that is available.

In addition, birth certificate and Medicaid Eligibility or Paid Claims files are not linked, nor are birth certificates and WIC eligibility files. Work is ongoing with the Colorado Department of Health Care Policy and Financing to obtain Medicaid data. Furthermore, the new birth certificate begun in January 2007 allows identification of Medicaid births. In turn, this should result in the ability to link claims data more easily.

The WIC data system is undergoing a large change at this time and the data are not currently linked. It is expected that in the future the files will be linked.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	2	Yes
Colorado Child Health Survey	3	Yes
Colorado Healthy Kids Survey on Tobacco	3	Yes

Notes - 2010

Narrative:
The Colorado Youth Risk Behavior Survey provides data on adolescent tobacco use every other year.

Child Health Survey data are provided annually. Results are tabulated in the spring of the year following the survey, which is conducted on an on-going monthly basis. Data for 2007 were made available in May 2008; data for 2008 were available in June 2009. The quick availability of the results greatly enhances program planning.

The Colorado Healthy Kids Survey on Tobacco (CHKS-T) was first conducted in fall 2001 and was repeated in fall 2006. The CHKS-T will be administered again in 2008 and every two years thereafter.

IV. Priorities, Performance and Program Activities

A. Background and Overview

This section of the grant provides detailed information on Colorado's priorities in maternal and child health. The priorities are addressed through both national and state performance measures. There are a total of 18 national measures and 10 state measures. Each of these is discussed in detail under each measure's heading (Sections IV C and D).

/2007/ No changes were made. //2007//

/2008/ State Performance Measure 4, the rate of birth for Latinas aged 15 to 17 has been discontinued. This is discussed further later in this section. //2008//

/2009/ State Performance Measure 6 Smoking Prior to Pregnancy will be discontinued. The activities associated with this measure are virtually the same as those associated with National Performance Measure 15. Work will continue in this area, but it will be reported for National Performance Measure 15. //2009//

/2010/ No changes were made. //2010//

B. State Priorities

Colorado's ten state priorities are:

1) Improve healthy birth outcomes for pregnant women
2) Improve access to health care for MCH populations
3) Improve immunization rates for all children
4) Reduce the adolescent fertility rate
5) Reduce rates of child and adolescent motor vehicle injury and death
6) Improve preconceptual health among women
7) Reduce the incidence of overweight among children and teens
8) Improve the mental health of MCH populations
9) Improve the health of children
10) Reduce the use of tobacco, alcohol and other drugs among MCH populations.

A chart showing the state priorities, the national performance measures, and the state performance measures is attached to this section. "Priority Areas, National Performance Measures, and State Performance Measures Colorado FY 06" delineates the relationship between the priority areas and the two types of performance measures.

The process used to determine the state's priority needs involved assessing the needs, examining the capacity, selecting the priority needs and performance measures, and setting the targets. We began with a comprehensive analysis of current data on the health status of the maternal and child populations that was utilized by state and local stakeholders and state-level program administrators and consultants in determining what the priority needs would be. This analysis, "The Health Status of Colorado's Maternal and Child Health Population" is contained in the Section II narrative.

In the 2005 Needs Assessment process, the input of multiple stakeholders was solicited. This was expedited through the use of internet resources that have become available in recent years. We began the needs assessment process with an electronic survey designed to solicit the perception of stakeholders from around the state regarding the needs and emerging issues. Our intent was to identify any additional issues for which we needed to gather data and information.

The health status report was successful in providing needed information from the responses of over 700 individuals, identifying access to care and the lack of insurance for specific populations and types of care as issues of concern for which we needed to seek out additional data. Such data was included in the "The Health Status of Colorado's Maternal and Child Health Populations" as a result. We also used an Internet-based technology, WebIQ, for the more comprehensive Stakeholder Input process that responded to the data in the health status report. In the 2005 Needs Assessment process a series of meetings that used Internet technology connected the stakeholders in a discussion of priorities and resulted in a ranking of the priorities.

The use of the Internet-based survey tool and the WebIQ technology for the participation of MCH stakeholders facilitated the participation of a much broader spectrum of stakeholders than was possible five years ago. The amount of time that the participants needed to commit to was limited to one hour sessions with several options of available dates and times. Participants could "attend" from their own offices, and could gathering appropriate staff members together who could participate simultaneously by conference call and through their computer keyboards. The technology allowed the participants' input to be displayed immediately, commented on, added to, voted on, and ranked using standardized criteria.

The data contained in "The Health Status of Colorado's Maternal and Child Health Population" provided the evidence upon which Colorado's priorities are based. The list of priorities for the next five years is similar to the list that was in effect for the past five years. This finding underscores the importance of addressing basic maternal and child health issues which may not be easily accomplished. Access to care, reduction of harmful behaviors, and improvement in healthy behaviors over time will lead us closer to fulfilling the goals that our priorities promise. Colorado's priorities cover a broad range of issues that are all important to the health of mothers and children in our state.

FY 2006 New Performance Measures

The following summarizes plans for addressing the new FY 2006 state performance measures resulting from the needs assessment process.

New State Performance Measure 4

The rate of birth (per 1,000) for Latinas aged 15-17

The FY 2006 target is set at 73.7 births per 1,000 teens age 15-17.

This target is the baseline level of Latina teen fertility for calendar 2003, the most current available. The primary intent of this project is to gain a fundamental understanding of the Latino/a teens, parents, and community providers' viewpoint on teen sexuality and pregnancy prevention. The Latina Teen Fertility Project has two phases (I and II) and the final report will provide baseline information for this measure.

The first phase of the Latina Teen Fertility Project began in August 2004 and continued through FY 2005. A contractor was hired to develop an exploratory study to explore the various sociocultural factors related to Hispanic/Latina teen pregnancy in Colorado. The contractor organized and facilitated 5 focus groups with community members in metro Denver to obtain the feedback of U.S.-born Latino/a teens and parents. Also, two meetings were held with representatives from community-based organizations that work directly with Latino/a adolescents to ask for their feedback regarding these complex issues. The same process was repeated to obtain the feedback of foreign-born Latinas/os, Spanish-speaking community members.

The findings from this first phase provided a wealth of information for consideration when developing initiatives to address Hispanic/Latina teen pregnancy. Input from teens, parents, and

community leaders demonstrated a critical need for more leadership from public health agencies in this area including providing funding and technical assistance for programs, and a firm and genuine commitment to work in collaboration with the community to address Hispanic/Latina teen pregnancy. The report from the first phase is attached to this section, after the injury fact sheet.

After the completion of Phase II begun in FY 2005, the results from both phases will be analyzed and compared, yielding possible appropriate programs strategies recognizing socio-cultural differences. The state health department will present the final findings of the Latina Teen Fertility Project to the public, and sponsor a community dialogue to discuss next steps. The project may be expanded (contingent upon funding) by conducting focus groups throughout Colorado to obtain representational statewide data.

Targets and specific plans for follow-up on this measure will be set during FY 2006.

New State Performance Measure 5

The motor vehicle death rate among teens 15-19

The FY 2006 target is 28.0 deaths per 100,000 teens.

According to the Health Statistics Section at the state health department, the motor vehicle death rate among teens age 15-19 in 2003 was 29.0 per 100,000. A fact sheet on deaths and hospitalizations involving teen drivers is attached to this section, following the chart on priorities.

Utilizing the Adolescent Health in Colorado 2003 Report, and building on existing statewide efforts, the Advisory Council on Adolescent Health will meet in the fall of 2005 to develop a work plan to decrease motor vehicle deaths among teens in Colorado. Experts on teen motor vehicle safety will present data to the Council, and state and local and best practices will be identified. We will invite participation from a broad base of stakeholders including the Injury Prevention Section at the state health department; AAA Colorado; representatives from law enforcement, schools, and injury prevention coalitions; parents; and teens. The steps will be incorporated into model work plans for local health departments and used to guide the activities of the state health department's Adolescent Health Program.

New State Performance Measure 6

The percent of mothers smoking during the three months before pregnancy

The FY 2006 target is 15.9 percent.

In Colorado, one out of every eight low birth weight births can be attributed to the fact that the mother was a smoker. In 2003, according to PRAMS data, 18.7 percent of women in Colorado were smokers prior to conception.

The state tobacco program (STEPP) and the Women's Health Section will continue to jointly conduct smoking cessation trainings for prenatal providers. Trainings are offered to prenatal providers from private practice, WIC, Prenatal Plus, Nurse Home Visitor Programs, local health departments, and hospitals on how to implement the 5A's counseling intervention with their patients and incorporate the technique into routine care. Another cessation initiative underway involves physician education through hospital grand rounds. Physicians deliver presentations to audiences of other physicians on tobacco cessation interventions and resources. The Women's Health Section is supporting these efforts by participating in displays and distribution of materials. Assessment and direct counseling for clients will continue at 30 family planning delegate agencies serving 55,000 clients per year and 27 Prenatal Plus agencies serving 3,500 clients per

year.

Colorado was selected to participate in the Action Learning Lab: Tobacco Prevention and Cessation for Women of Reproductive Age sponsored by the American College of Obstetricians and Gynecologists (ACOG) and the Association of Maternal and Child Health Programs (AMCHP). The Colorado state team includes members from STEPP, the Women's Health Section, ACOG, Planned Parenthood of the Rocky Mountains, and the March of Dimes. A statewide action plan is being developed to increase collaboration and comprehensive implementation. Through trainings and presentations, we will educate health care providers and provide smoking cessation materials at no charge.

STEPP will promote awareness of the Colorado Quitline (smoking cessation telephone line) among pregnant smokers with television ads that will run statewide using the "You Have the Power" ad from the CDC's media resource center. In addition, several different print ads targeting pregnant smokers will be provided to local health departments for their use in community newspapers.

New State Performance Measure 7

The proportion of all children 2-14 whose BMI is greater than 85 percent weight for height

The target has not yet been set.

Data from the 2004 Colorado Child Health Survey will be analyzed for this measure. Survey questions focus on the health and health behaviors of a randomly selected child in the household (the full format of the survey and all survey questions are attached to Section III F). Parents are asked to actually weigh and measure the child prior to the survey and there are an additional nine questions regarding nutrition.

Data from the 2004 Colorado Child Health Survey indicated that 14.2 percent of children have a BMI greater than 85 percent weight for height. The full survey will be analyzed along with demographic and companion information and a target will be determined.

The state health department's Child, Adolescent and School Health Section, Colorado Physical Activity and Nutrition (COPAN) Program, and WIC Program will work collaboratively with the Healthy Child Care Colorado Project, the Coordinated School Health Program, the Colorado Department of Education and other interested state and local agencies and organizations to develop strategic state and local action steps to address the issue of overweight/obesity among children and adolescents.

In addition, the Child, Adolescent and School Health Section will assess the impact of providing "incentive grants" to local public health agencies in communities whose schools are receiving CDC Coordinated School Health grants. The efficacy and impact of this funding in addressing obesity prevention and healthy lifestyle promotion among the school age population will also be determined.

New State Performance Measure 8

The percent of children who have difficulty with emotions, concentration or behavior

The target for FY 2006 is 28.0 percent.

The target is based on the preliminary estimate of children with difficulties with emotions, concentration or behavior using preliminary 2004 data from the Child Health Survey.

The Child, Adolescent and School Health Section within the Maternal and Child Health Program at the Colorado Department of Public Health and Environment has applied for a grant from MCHB to improve coordination of state mental health prevention, intervention and treatment systems through a collaborative planning process. Recommendations will be prioritized and operationalized through the Prevention Leadership Council, an existing state-level body that is charged with coordinating and streamlining state and federally funded programs that is led by the Colorado Department of Public Health and Environment. Improved state coordination will lead to local services integration, increased access to mental health care, and better mental health outcomes among children, youth and families. If the MCHB grant is not funded, alternate funding will be sought.

New State Performance Measure 9

The percent of center-based child care programs using a child care nurse consultant

The target has not yet been set.

Qualistar Early Learning is a nonprofit organization dedicated to improving child development and age-appropriate learning experiences for all children. It conducts an annual survey of child care providers through the child care resource and referral network throughout the state. In order to obtain baseline data for this performance measure, the MCH Program plans to sponsor questions on the Qualistar survey to determine how many child care providers are actively using child care health consultants and to ascertain how satisfied the provider is with the consultation services they are receiving.

New State Performance Measure 10

The proportion of high school students reporting binge drinking in the past month

The FY 2006 target is 29.0 percent.

According to the 2003 Colorado Youth Risk Behavior Survey, 29.1 percent of students reported report having drunk five or more drinks in a row (binge drinking).

Colorado has received a $2,350,965 grant from the Substance Abuse and Mental Health Services Administration to advance community-based programs for substance abuse prevention, mental health promotion and mental illness prevention. The program, which is housed in the Alcohol and Drug Abuse Division (ADAD) at the Colorado Department of Human Services, is a collaborative effort between the ADAD and the Prevention Leadership Council. The Director of the Adolescent Health Program will work collaboratively with ADAD, the Advisory Committee and the Underage Drinking Workgroup to develop strategic state and local action steps to address the issue of binge drinking among teen.

/2007/

No changes were made. //2007//

/2008/
State Performance Measure 4, the rate of birth (per 1,000) for Latinas aged 15-17, has been discontinued as the activities designated for state staff are now complete. Future activities regarding this project will be done by a non-profit organization. The state will continue to monitor activities but will no longer take the lead. See State Performance Measure 4 narrative for more information.

State staff are engaging in a critical review of state-level MCH activities during the summer and fall to better re-define priorities and state-level work in response to data trends and MCH funding reductions. //2008//

/2009/ State Performance Measure 6 Smoking Prior to Pregnancy will be discontinued. The activities associated with this measure are virtually the same as those associated with National Performance Measure 15. Work will continue in this area, but it will be reported for National Performance Measure 15. //2009//

/2010/ No changes were made. //2010//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	98	98	100	100	100
Annual Indicator	98.0	100.0	100.0	100.0	100.0
Numerator	67920	213	77	54	63
Denominator	69304	213	77	54	63
Data Source					CDPHE Newborn Screening Laboratory
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
Data shown for reporting year 2008 are based on calendar year 2007 births.

Notes - 2007
Data shown for reporting year 2007 are based on calendar 2006 births.

Notes - 2006
Data shown for reporting year 2006 are based on calendar 2005 births. The numbers shown for reporting years 2005 to 2008 are limited to the number of screen positive newborns. Numbers shown for earlier years reflect all newborns.

a. Last Year's Accomplishments
The target for reporting year 2008 was 100.0 percent and it was met (using calendar 2007 data). A total of 63 screen positive newborns received timely follow up to definitive diagnosis and clinical management for their conditions.

The Newborn Metabolic Screening Program does not yet have the capability to exactly match newborn screening samples with birth certificates (including home births), and thereby ensure that 100 percent of newborns in Colorado are screened. Work continued on meeting this goal. About one percent of Colorado infants are born at home and many of these parents refuse the screen, as do a small number of parents of babies born in hospitals. The state does not require that paperwork on these refusals be filed with the state screening program.

A new parent brochure was produced to reflect the addition of the expanded Newborn Screening conditions.

A disaster plan for the newborn screening follow-up program was submitted as part of the FEMA Continuation of Operations Plan.

Metabolic physicians advocated that any delay in diagnosing certain newly added metabolic conditions could lead to death or serious illness. The Board of Health revised the department's rules and regulations for newborn screening. The provision allowing a one-week delay for the initial screening of sick and/or premature neonates was removed. All babies, regardless of gestational age and/or health status, must be screened by no later than 72 hours of age.

The state laboratory and the Inherited Metabolic Disease clinic at The Children's Hospital in Denver made a concerted effort to encourage the 24 hospitals located on the front range of Colorado (Denver plus 100 miles north and south, on the eastern side of the mountains) to use courier services rather than the mail to transport newborn screening specimens to the state health department screening laboratory. It had been observed that specimens sent by courier were received sooner than those sent by US Mail. As a result of these efforts, 17 of the 24 hospitals are using courier services, thereby significantly shortening the length of time from date of birth to date of specimen receipt and testing.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. A new parent brochure was developed.			X	
2. A disaster plan for the Newborn Screening Follow-up Program was developed.				X
3. The department's rules and regulation were revised so that all infants are screened within 72 hours.	X			X
4. Shortened the length of time from date of birth to date of specimen receipt and testing.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2009 is for 100.0 percent of screen positive newborns to receive timely follow up to definitive diagnosis and clinical management for their conditions.

The CDPHE Laboratory, the Immunization Registry, and the Newborn Metabolic Screening Follow-Up Program met to discuss how to integrate data systems. A strategic plan to implement integration is under development. These changes will allow health care providers to know more

about the immunization, screening and hearing screening status of the infants in their care, ultimately ensuring more children receive screenings and needed follow-up.

The state added DNA mutation analysis as one of the elements in the screening protocol for cystic fibrosis (CF) screening, resulting in the identification of "CF carriers." Carriers were not identified in the program's previous protocol. There is consensus among many decision makers in this field that parents who have been identified as carriers should receive some genetic counseling. A system for providing this counseling, which involves coordination and cooperation among the state laboratory, the CF Center at The Children's Hospital and the Newborn Metabolic Screening Program was developed and is being refined.

Cross-training between the newborn metabolic and newborn hearing screening follow-up coordinators was designed and incorporated into program activities in the fall of 2008.

c. Plan for the Coming Year

The target for reporting year 2010 is for 100.0 percent of screen positive newborns to receive timely follow up to definitive diagnosis and clinical management for their conditions.

The composition of the Newborn Screening Advisory Committee's membership categories will be reviewed to determine if all professional and lay members groups are represented. There have been many developments in the field of neonatal medicine since 1990, when the categories were designated; it is anticipated that changes will be made.

The state's Newborn Metabolic Screening Advisory Committee will be interviewed by researchers from Utah about the state's policy regarding the availability of stored blood specimens for research purposes. The interview is part of an NIH-sponsored grant held by Utah.

In addition to ongoing cross-training between the newborn metabolic and newborn hearing screening follow-up coordinators, certain responsibilities and duties of the two positions will be reapportioned to maximize efficiency and optimal use of resources.

The program will continue to add information to the disaster plan for Colorado's Newborn Metabolic Screening Program in categories that were not addressed or required in the already completed FEMA Continuation of Operations Plan planning template.

Continued integration of data between the Immunization and the Newborn Screening Programs will offer another way to ensure that all babies (whose parents elect to do so) are screened. Data integration with the electronic birth certificate and the Immunization Registry will also offer health care providers another way to identify if a child has had a hearing screening, thus enhancing the safety net to ensure all infants are screened.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	55	57.4	57.4	57.4	60
Annual Indicator	57.4	57.4	57.4	59.1	59.1
Numerator					
Denominator					

Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	60	60	61	61	61

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The next survey went out in the field in early 2009, so reporting year 2008 data repeats the data shown for reporting year 2007.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
The target for reporting year 2008 was 60.0 percent and it was not met (using data from 2005-2006). The indicator showed that 59.1 percent of families with children with special health care needs partnered in decision making at all levels and were satisfied with the services they received.

As a result of a November 2007 forum, a Family Leadership Coalition was formed under the leadership of the Children with Special Health Care Needs (CSHCN) Unit. The coalition included emerging family leaders and groups such as the Partnership for Families and Children, Family Resource Centers, Family Voices Colorado, Head Start, the University of Denver and the Colorado Statewide Parent Coalition. The Family Leadership Coalition is also supported by state agencies including the Lieutenant Governor's Office, the Colorado Department of Public Health and Environment, the Department of Human Services, the Division of Developmental Disabilities, and the University of Colorado Health Sciences Systems.

The Family Leandership Coalition expects that programs, services and initiatives will be more youth/family-centered as a result of integrating the consumer voice at all levels. It was formed as a cross-agency group interested in developing infrastructure for training and deploying youth/family leaders. It matches youth/family leaders with needed skills to advisory boards and agencies that want a consumer voice. The coalition offers training opportunities for youth/family leaders and agency staff to ensure consistency in expectations.

The coalition identified a family leadership curriculum that is evidence-based that will encourage family empowerment leading to systems change. It is the Parent Leadership Training Institute developed by the Connecticut Commission on Children. Evaluation of the curriculum showed positive change in three domain areas: parents, children and the community. The coalition will offer the curriculum to Colorado communities as a grass-roots approach to civic engagement.

The Colorado effort was renamed the Family Leadership Training Institute to promote a broad definition of family beyond parents. Additionally, the curriculum was customized with consultation from local policy experts to address Colorado policy and political culture.

After participating in a readiness assessment by the Connecticut technical assistance team, the CSHCN Unit sponsored two Parent Leadership Training Institute (PLTI) trainings. In June 2008, 28 facilitators were selected from 35 nominees; they participated in a three-day training from the Connecticut technical assistance team. The training's primary outcome was the formation of a cadre of facilitators equipped to teach the class in selected local communities. In August, a second training was held to train coordinators on the logistics of community organizing to assure community readiness for the PLTI. Action plans were developed that included outreach, fundraising and overall implementation logistics strategies. The Adams and Arapahoe county teams finalized their plan to use the curriculum in the first quarter of 2009. Denver and Larimer counties will launch the curriculum in the fourth quarter of 2009.

Health care reform was a state priority as evidenced by the Colorado's Senate Bill 07-208 Commission on Health Care Reform. Several family leaders, supported by the CSHCN Unit, were involved in the work of the Commission to ensure that family satisfaction and informed decision-making was a part of this critical process.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. A Family Leadership Development Coalition was formed.				X
2. A statewide Family Leadership Forum was held to discuss strategies to establish and sustain a strong network of family leaders.				X
3. Initiated the Parent Leadership Training Institute.				X
4. Parents were involved in Colorado's Senate Bill 07-208 Commission on Health Care Reform.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The target is 60.0 percent.

In February, the pilot program for the Family Leadership Training Institute (FLTI) was launched in Arapahoe and Adams counties. Over 40 applications were received and 29 people were selected to participate in the two classes. Four previously trained facilitators and a site coordinator were assigned to each class. All class participants were required to plan and implement a community project.

Colorado's Family Leadership Coalition continued to grow with nearly 40 organizations and individuals participating. The group is exploring diversified funding, such as grants and agency sponsorship, to expand access to the FLTI.

Nearly 200 people attended a Colorado Summit on Cultural Competence held in October that featured Wendy Jones from the National Center for Cultural Competence. A follow-up session was held in April to provide continued technical assistance to communities and agencies.

The Colorado Family Leadership Registry was developed as a tool for families, agencies, communities and policymakers. The registry was designed to ensure meaningful family participation in organization activities by linking trained volunteers with agencies seeking meaningful family participation. Registry members are graduates of the leadership training program willing to assist agencies by reviewing and commenting on policies, documents or other resources. An agreement was established between CDPHE and the Department of Education to identify new participants.

c. Plan for the Coming Year

The target for reporting year 2010 is for 60.0 percent of families with children with special health care needs to partner in decision making at all levels and to be satisfied with the services they receive.

The activities described above will continue.

The Colorado Medical Home Initiative (CMHI) will continue to promote and support family leadership and parent/professional partnerships. The Family Leadership Taskforce will offer guidance to the CMHI regarding state and local implementation activities.

A logic model and a strategic plan for family leadership development will be completed and used to drive the work of the Family Leadership Coalition.

The Family Leadership Training Institute will expand to at least two more communities. Technical assistance will continue from Connecticut to ensure that the Institute graduates leaders with community-based leadership skills.

The CSHCN Unit Regional Family Coordinators will continue to support efforts related to enhancing parent satisfaction and parent/professional partnerships. The work of Regional Family Coordinators is determined locally and may include activities such as following up on patient satisfaction, outreach and support activities with other parents.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	50	51.7	51.7	51.7	51.7
Annual Indicator	51.7	51.7	51.7	48.2	48.2
Numerator					
Denominator					
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

	2009	2010	2011	2012	2013
Annual Performance Objective	51.7	51.7	52	52	52

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The next survey went out in the field in early 2009, so reporting year 2008 data repeats the data shown for reporting year 2007.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
The target for reporting year 2008 was 51.7 percent and it was not met (using 2005-2006 data). The indicator showed that 48.2 percent of children with special health care needs received coordinated, ongoing, comprehensive care within a medical home.

Beginning in October 2007, the Colorado Medical Home Advisory (MHA) and the MHA Steering Committee developed a formal organizational structure including a meeting schedule, membership, member roles, and responsibilities, steering committee, and task forces.

The MHA Evaluation Taskforce developed Medical Home Assurances and Standards (MH Standards) (attached) for each of the six medical home components. The MH standards were selected based on a statewide survey resulting in over 500 responses from MHA members, family leaders, and community partners. The standards were finalized by the MHA in May 2008 and submitted to the Colorado Department of Health Care Policy and Financing (HCPF) Office of Client and Community Relations. HCPF included the standards in the Medicaid and Child Health Plan Plus (CHP+) contracts. The CSHCN Unit used the standards to guide community medical home systems development and provider capacity building.

The MHA Provider and Practice Management Taskforce (MHA PPM TF) offered a forum to review the MH Standards prior to finalization. The group also began to identify the provider priorities for support and resource needs for implementing the Standards. This information was used by CDHCPF to develop provider and community medical home systems training programs.

The MHA Family Leadership Taskforce received input from diverse group of families about the best ways to educate families on leadership opportunities. Facilitators were trained in the Family Leadership Training Institute curriculum.

The MHA Messaging Taskforce gathered information from other state programs and medical home websites. The Washington medical home website was selected as a model. The state health department and HCPF will work together to develop the Colorado Medical Home website.

In February, a HRSA State Implementation Grant for Integrated Community Systems for CSHCN was submitted, focused on the need to assure that all providers of a child's health care team operate so that: families are critical team members; team members implement quality, coordinated medical, mental, and oral health care, and public health and clinical health care providers collaborate at the individual family and child and community levels.

In June 2008, an interagency state team was selected to attend and present at the national

summit of the National Association of State Health Plans to share and further develop best practices related to the Medical Home approach. As a result, HCPF and the state health department developed a report summarizing activities related to the inter-agency work within the Medical Home Initiative.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Engaged in infrastructure development for the Colorado Medical Home Advisory Board.				X
2. Advisory Board taskforces carried out their respective workplans.				X
3. A State Implementation Grant for Integrated Community Systems for CSHCN was submitted to HRSA and accepted.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2009 is for 51.7 percent of children with special health care needs to receive coordinated, ongoing, comprehensive care in a medical home.

The Medical Home Initiative worked on health care systems integration with a broad array of internal and external partners.

The Evaluation Taskforce activities were integrated into the core work of the Initiative based on the need for a broader evaluation focus. A Medical Home Logic Model was developed and project outcomes identified. (attached).

The Medical Home Advisory (MHA) monthly meetings provided a forum for partners to share best practices.

The MHA Family Leadership Taskforce developed a structure for the Family Leadership Institute Trainings and created the Family Leadership Coalition. Support was given to the Family 2 Family project.

The MHA Messaging Taskforce is working is developing a medical home website at the state health department. Resources and materials are being identified to include on the website.

The CSHCN Unit completed the Colorado Medical Home Action Guide to assist local public health agencies champion a medical home approach for CSHCN.

The Unit's Integrated Data System was adapted to begin collecting HCP care coordination data. Data entry trainings will begin in the fall.

Interagency work continues between CDPHE and HCPF on such medical home related projects as the Center for Improved Value in Health Care, Patient-Centered Medical Home, and the Accountable Care Collaborative.

An attachment is included in this section.

c. Plan for the Coming Year
The target for reporting year 2010 is for 51.7 percent of children with special health care needs receive coordinated, ongoing, comprehensive care within a medical home.

The program will continue to evaluate the MHI systems integration outcomes using the MH Logic Model and MHI Strategic Plan.

Work will continue with HCPF on its efforts to establish Accountable Care Collaborative regional centers to support the delivery of primary health care for children on Medicaid.

The MHA will meet regularly and address medical home implementation strategies at the state and local levels and track the broad range of medical home implementation projects across the state.

The Family Leadership Task Force will support the Family Leadership Training Institute, Family Voices education and advocacy on family centered care, and the Family 2 Family health information grant.

The MHA Provider and Practice Management Taskforce will use the Medical Home website, web trainings, and meetings with providers and practice managers to share information about available supports and resources. They will also work with partners to address gaps in services for families and providers.

The MHA Messaging Taskforce will continue the development of the Medical Home website for use by families, providers, and community partners. In addition, brochures, training modules and other education materials will be developed to support consistent messaging and technical assistance to consumers and providers.

The CSHCN Unit continues the HRSA Integrated Community Systems Grant for CSHCN. Mesa, Larimer, Boulder and Summit counties will participate in the evaluation of the three-year grant project. All communities will participate in developing best-practice documents for use by other communities implementing the Medical Home Initiative.

The Unit will monitor and analyze care coordination outcomes to determine their validity. It will also monitor systems modification and future training needs. These analyses will assist in identifying additional care coordination outcomes and the most effective care coordination intervention strategies.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	55	58.2	58.2	58.2	60
Annual Indicator	58.2	58.2	58.2	59.1	59.1
Numerator					
Denominator					
Data Source					National

					Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	60	60	60	60	61

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The next survey went out in the field in early 2009, so reporting year 2008 data repeats the data shown for reporting year 2007.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
The target for reporting year 2008 was 60.0 percent and it was not met (using 2005-2006 data). The indicator showed that 59.1 percent of families with children with special health care needs had adequate private and/or public insurance to pay for the services they needed.

The Medicaid & Kids and the Covering Kids and Families Coalitions continued to work with statewide partners to share information and to simplify the public insurance application process. The Coalitions continued to train community-based sites on how to enroll participants into CBMS, the state electronic application program for both Medicaid and Child Health Plan Plus (CHP+). Information was provided to coalition members and their constituencies regarding program changes.

The Medical Home Initiative continued to work with the Colorado Department of Health Care Policy and Financing (HCPF) to improve medical home practices. This statewide collaboration, defined in the 2007 Medical Home legislation, SB 07-130, is a joint project between the CSHCN Unit and HCPF.

The Colorado Children's Healthcare Access Program (CCHAP) and the CSHCN Unit worked to expand the number of providers willing to accept public insurance reimbursement and become medical homes through a HRSA systems integration grant. CCHAP worked with local community partners including the Health Care Program for Children with Special Needs (HCP). There were 90 local providers in Boulder County and 14 providers in Summit County that participated in the project.

The CSHCN Unit led efforts within the Medical Home Initiative Provider Taskforce to carry out activities associated with the Provider Support Needs, Resources, Gaps, and Recommendations Report developed from the Home Standards.

The System of Care Collaborative of Colorado, LINKS (Linking Interagency Networks for Kids'

Services) and the Family and Child Subcommittee of the Colorado Mental Health Advisory Council worked together to identify how best to enhance access to care, while maintaining a family-centered mental health focus.

State CSHCN staff participated on the state health department's Maternal and Child Health Access to Care Task Force to determine the outcome of local public health's efforts to assist with presumptive eligibility and enrollment of children into public insurance programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participated in the Medicaid & Kids and the Covering Kids and Families Coalitions.				X
2. The Coalition continued to train community-based sites on how to enroll participants into Medicaid.		X	X	
3. Worked to expand the number of providers willing to accept public insurance reimbursement and become medical homes for these children.				X
4. The Medical Home Initiative Provider Taskforce defined Medical Home Standards and increased the number of participating Medicaid providers.				X
5. Explored how to support access to mental health services.				X
6. Participated on the CDPHE, Maternal and Child Health Access to Care Taskforce				X
7.				
8.				
9.				
10.				

b. Current Activities
The target for reporting year 2009 is 60.0 percent.

Work continued with the Medicaid & Kids and the Covering Kids and Families Coalitions to share information, simplify the public insurance application process and identify concerns for families using public insurance.

The Medical Home Initiative continued efforts focused on improving provider ability to offer timely and culturally responsive family-centered care within the Medical Home. Monthly Medical Home Advisory (MHA) meetings were used to share best practices strategies. Members of the MHA Provider and Practice Management Taskforce presented this information.

The Blue Ribbon Policy Council published the Colorado State Strategic Plan for Early Childhood Mental Health in November 2008. The recommendations incorporate a prevention and health promotion model. The System of Care Collaborative of Colorado, consisting of various community partners who are concerned with the mental health needs of children and their families, worked on how to reduce the barriers to care. The collaborative is developing better agreements between various community partners that recognize the barriers and want to strengthen access to care for children and their families.

State CSHCN staff participated on the state health department's Maternal and Child Health Access to Care Task Force to determine the outcome of local public health's efforts in assisting with presumptive eligibility and enrollment of children into public insurance programs.

c. Plan for the Coming Year
The target for reporting year 2010 is for 60.0 percent of families with children with special health care needs to have adequate private and/or public insurance to pay for the services they need.

Activities will continue from the previous year.

The CSHCN Unit will work with the Department of Health Care Policy and Financing (HCPF) EPSDT Program to determine how to be reimbursed for HCP Care Coordination. This may occur by contracting for targeted CSHCN case management services as a part of the Accountable Care Collaborative which is part of Medicaid reform efforts. Regional organizations will offer care-coordination services and support the local participating providers and clients in the regions. In exchange for the additional clinical support, providers will be asked to offer increased access to clients (extended office hours, some same-day appointments, etc.) and to begin to use state-supplied health information technology.

The Early Childhood Mental Health Infrastructure Committee will suggest how to build infrastructure within various community partner organizations to better achieve the recommendations from the recently released strategic plan. The System of Care Collaborative of Colorado, the Federation of Families for Children's Mental Health of Colorado and LINKS will work with other state partners to determine how best to develop systems agreements that result in a seamless mental health continuum of care for families. The Family and Child Subcommittee of the Mental Health Policy and Advisory Council for the State of Colorado will provide training to the overall council regarding the needs of children and their families.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	75	77.4	77.4	77.4	87.8
Annual Indicator	77.4	77.4	77.4	87.8	87.8
Numerator					
Denominator					
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	87.8	88	89	89	90

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The next survey went out in the field in early 2009, so reporting year 2008 data repeats the data shown for reporting year 2007.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
The target for reporting year 2008 was 87.8 percent and it was met (using 2005-2006 data). The indicator showed that 87.8 percent families with children with special health care needs reported the community-based service systems were organized so that they could use them easily.

The Children with Special Health Care Needs Unit was awarded a three-year grant from the Maternal and Child Health (MCH) Bureau, entitled State Implementation: Integrated Services for Children with Special Health Care Needs. The Medical Home Teams were convened in Boulder and Summit counties to identify and overcome barriers (i.e. coordination across agencies) to assuring a medical home approach for all children including those with special health care needs.

A new focus for the HCP program was established and a tool was made available for local contractors called the HCP Medical Home Action Guide. The guide outlines how local communities can work to implement a medical home approach and a community-based medical home system for children with special needs.

HCP contractors in every county provided care coordination and local systems building incorporating family involvement and leadership.

The CDPHE CHIRP (Clinical Health Information Records of Patients) data system reports there were 2,101 community encounters by public health contractors with other providers, agencies and organizations to organize services for ease of use by families.

Access to specialty medical providers was addressed through 99 Specialty Clinics (Orthopedic 8, Neurology 64, Cardiology 5, Rehabilitation 18, Pediatric 4). There were 1,195 total completed patient visits offered through 14 specialty clinic sites in 14 counties.

CHIRP data indicates 10,141 families received care coordination services.

Parent coordinators were hired in 14 of the 17 regional offices to assist with local systems development, parent to parent support and to consult with care coordinators.

A state level historical perspective of HCP care coordination was developed.

An Analysis plan was designed to look at current and future HCP care coordination services.

A Family Leadership Training Institute (FLTI) was developed in partnership with the Foundation for Children and Families. The FLTI is modeled after the Parent Leadership Training Institute in Connecticut. Leaders from five Colorado communities were trained to develop community leadership projects.

The Developmental Evaluation Clinic program in eight sites statewide developed community

plans to coordinate with primary care providers and to offer care coordination for families needing these clinic services. A developmental pediatrician provided care in eight sites and saw 302 children.

An interagency agreement was signed with Early Intervention Colorado (Part C) to maintain coordination at the state and local level for children birth to three years of age who needed health or related services.

Respite care programs continued in six communities. Multiple private, public and non-profit organizations, such as Easter Seals, participated in the planning of the centers, as well as providing funding and personnel for implementation. University training programs in Denver and Alamosa identified nursing and special education students to work in the respite centers as part of their practicum requirements.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Received a three-year grant to integrate services for children with special health care needs.				X
2. Received a Early Hearing Detection and Intervention (EHDI) grant to overcome barriers to follow-up and support early intervention.				X
3. The HCP Medical Home Action Guide was developed.				X
4. A historical perspective of HCP care coordination was developed.				X
5. A Family Leadership Training Institute was initiated.				X
6. Developmental Evaluation Clinics program were held in six sites.	X			
7. Signed an interagency agreement with Early Intervention Colorado (Part C) to maintain coordination at the state and local levels.				X
8. Offered respite care programs continued in six communities.	X	X		
9.				
10.				

b. Current Activities

The target for reporting year 2009 is for 87.8 percent of families with children with special health care needs to report that the community-based service systems are organized so they can use them easily.

The Integrated Services grant continued in Boulder and Summit counties. Larimer and Mesa county leaders began work on this project and convened community partners, including physicians, to address local systemic issues, such as how to better coordinate Medical Home projects.

CSHCN national survey data was used in local planning to develop outcomes for care coordination. Three levels of care coordination were defined to better assess activities, cost and capacity of the local offices. (attachment)

Adams and Arapahoe counties implemented the Family Leadership Training Institute (FLTI) program and provided the eleven-week training. These parent leaders will work with local HCP projects to assure family/consumer involvement in health care and medical home projects.

Two local HCP staff began a statewide Respite Care Coalition. A state survey was conducted and the results have been shared with the coalition.

HCP care coordination services expectations have been refined and trainings are being developed to address these new expectations. A care coordination evaluation plan was developed.
An attachment is included in this section.

c. Plan for the Coming Year
The target for reporting year 2010 is for 88.0 percent of families with children with special health care needs to report that the community-based service systems are organized so they can use them easily.

Activities described above will continue.

The Integrated Services grant year-one communities will present their findings to the Colorado Medical Home Initiative Advisory Board and the Colorado Public Health Association at the annual conference in October 2009.

The HCP Program will provide training on the three levels of care coordination, including traumatic brain injury care coordination. The new data collection process and focus on program outcomes will also be addressed.

The Family Leadership Training Institute and the Colorado Respite Coalition will seek funding to expand their respective programs to more communities.

The recently developed coordination evaluation plan will be implemented begining in January 2010. The logic model identifies both short and long-term outcomes for care coordination. Information will be collected from assessment data, service information, and questionnaires completed by care coordinators.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	8	10	12	14	47
Annual Indicator	5.8	5.8	5.8	47	47
Numerator					
Denominator					
Data Source					National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-					

year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	48	48	48	49	49

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The next survey went out in the field in early 2009, so reporting year 2008 data repeats the data shown for reporting year 2007.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
The target for reporting year 2008 was 47.0 percent and it was met (using 2005-2006 data). The indicator showed that 47.0 percent of youth with special health care needs received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

State staff, in collaboration with county health agency personnel, continued to refine and distribute guidelines and resource materials to promote health care transition. Training and consultation continued regarding the use of the Guide to Transition Services for Youth with Special Health Care Needs.

Promotion of transition planning as an essential element of a medical home approach continued. Transition objectives were required to be included in care coordination plans for children. These standards were distributed to local health agency teams and other personnel who participate in regional Diagnostic and Evaluation Clinics.

An action guide was developed to facilitate the inclusion of health care transition activities into strategic planning. Strategies focused on three areas: leveraging the strengths and assets of community partners; establishing MCH connections between local schools; and providing transition planning and consultation services through HCP Care Coordination and Specialty Clinics.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Refined and continued to distribute guidelines and resource materials to promote health care transition.			X	
2. Transition objectives were required to be included in care coordination plans for children.	X	X		
3. An action guide was developed that addresses health care transition activities.				X

4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The target is 48.0 percent.

Work continues between the health department's CSHCN Unit and the Child and Adolescent Health (CASH) Unit. A coalition was formed composed of state agency personnel working on issues surrounding adolescents and young adults. The team's goal is to raise awareness, promote, enhance, unify and increase positive youth development efforts and strategies across the state.

The coalition compiled a resource guide of state agency leaders working on issues surrounding adolescents and young adults. The document includes 49 state employees from 10 state agencies. The tool provides contact information and a summary of each person's focus area.

Both state and regional personnel have participated in Colorado Youth Development Team activities within the CASH Unit. A statewide online survey and 13 community "conversations" were held focusing on positive youth development. The purpose of the meetings was to solicit participation and input from local partners, youth and families regarding how the state can better support youth development in local communities across Colorado. A final report is due this summer.

Staff worked closely with regional teams that have identified transition as a local priority. Guidance was given on how to include health care transition planning as an essential element of a Medical Home Approach, via care coordination practices, MCH-sponsored clinics and resource materials provided to schools, medical practices and other groups.

c. Plan for the Coming Year
The target for reporting year 2010 is for 48.0 percent of youth with special health care needs to receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

The CSHCN Unit continues to promote health care transition planning as an essential element of a medical home approach and to work with school personnel and health care providers to inform, empower and connect youth and families with the services they require.

The Unit will focus on assessing what activities make a difference in connecting youth and families with the services required to transition to adult health care, work, and independence. A survey is being developed that will ask school personnel (counselors, special educators, school nurses) and health care providers about their awareness of this issue and knowledge of resources that help transitioning youth. Topics may include transition to adult providers for youth; youth talking to their providers about changing health care needs; changes in eligibility for insurance; and strategies to encourage and permit youth to take responsibility for their own health care needs. The survey will also probe why topics are not addressed and how to overcome any identified barriers.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	88	90	90	90	85
Annual Indicator	67.5	77.1	83.4	80	78.6
Numerator					
Denominator					
Data Source					2007 National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	80	80	85	90	90

Notes - 2008
Data shown for 2008 are data for the 4:3:1:3:3 series for calendar year 2007 from the National Immunization Survey. See http://www.cdc.gov/vaccines/state-surv/imz-coverage.htm#nis.

Notes - 2007
Data shown for 2007 are data for the 4:3:1:3:3 series for calendar year 2006 from the National Immunization Survey. See http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#nis.

Notes - 2006
Data shown for 2006 are 2005 data for the 4:3:1:3:3 series from the National Immunization Survey.

a. Last Year's Accomplishments
The target for reporting year 2008 was 85.0 percent and it was not met (using calendar year 2007 results). The indicator showed that 78.6 percent of 19 to 35 month olds received the full schedule of appropriate immunizations.

The Vaccine Advisory Committee for Colorado (VACC) was established to examine barriers to childhood immunizations, identify pockets of need and recommend strategies for increasing immunization coverage for all Coloradans. The committee's mission is to ensure that every Colorado parent who wants his or her child fully immunized will experience no financial or structural barriers. The goals of VACC were outlined and the group developed a workplan to direct their activities. The VACC includes broad representation from key stakeholders in the fields of public health, school health, child advocacy, health care, philanthropy and academia; it is co-chaired by Lieutenant Governor Barbara O'Brien.

A series of strategic objectives were established to guide VACC's work to aggressively pursue the overall goal of Colorado being among the top-ranked states for childhood immunization coverage. The VACC Steering Committee established five subcommittees: Immunization Best

Practices, CIIS Registry, Innovative Health Programs, Special Projects and Public Awareness and Education. The subcommittees will be responsible for carrying out work plan goals and objectives. The VACC Steering Committee will also expand its advisory role to the Department of Public Health and Environment and the Lieutenant Governor's Office.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ensured VFC/AFIX visits were conducted in private provider offices and community health centers.	X	X	X	X
2. Continued collaboration through VACC.				X
3. Engaged in immunization week activities.	X	X	X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2009 is for 80.0 percent of 19 to 35 month olds to receive the full schedule of appropriate immunizations.

Colorado's immunization registry, referred to as the Colorado Immunization Information System (CIIS), was physically relocated from the University of Colorado at Denver to the Colorado Immunization Program at the Colorado Department of Public Health and Environment. This move represents the beginning of a critical evolution of the registry from an academic to an integrated core public health program.

Legislation was passed to expand the Colorado Immunization Information System (CIIS) to include vaccinations for all ages. This expansion will allow CIIS to receive and retain vaccine records for all patients beyond the pediatric ages.

Additional new state funding continued to support the state's local health departments and county public health nursing services to improve their infrastructure for administering and tracking immunizations. Competitive grants were awarded to select Colorado local health departments and county public health nursing services that proposed new, unique approaches for conducting immunization clinics. The goal of these outreach clinics was to reach children not fully immunized, with a priority on administration of the fourth DTaP.

The Vaccine Advisory Committee for Colorado (VACC) continued to meet and carry out work plan activities.

c. Plan for the Coming Year

The target for reporting year 2010 is for 80.0 percent of 19 to 35 month olds to receive the full schedule of appropriate immunizations.

Activities will continue from the previous year.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	28	24	23.5	23	22
Annual Indicator	24.6	24.8	23.8	23.7	22.1
Numerator	2304	2357	2281	2312	2200
Denominator	93810	94969	96001	97617	99489
Data Source					Birth Certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	21.5	21	20.5	20	19.5

Notes - 2008
Data shown for reporting year 2008 are calendar year 2007 births. This data is provided in the Colorado Births and Deaths document available at http://www.cdphe.state.co.us/hs/mchdata/mchdata.html.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data.

Notes - 2006
Data shown for reporting year 2006 are calendar year 2005 data.

a. Last Year's Accomplishments
The target rate for reporting year 2008 was 22.0 per 1,000 and it was essentially met with a rate of 22.1 (using calendar year 2007 data). A total of 2,200 births occurred among 99,489 teenagers aged 15 through 17 years.

The Women's Health Unit worked closely with the state Medicaid Program to submit a Medicaid 1115 Family Planning Waiver to expand services. Approval from the Centers for Medicaid and Medicare (CMS) is still pending.

The Family Planning Program received substantial funding from a private foundation to expand clinical services and provide long-term efficacious contraceptives to men and women through the Colorado Family Planning Initiative. This initiative includes outreach to teens with the goal of decreasing unintended pregnancies in Colorado.

The Adolescent Sexual Health workgroup was initiated to develop joint strategies and increase collaboration in this area.

A team from Colorado participated in the Moving from Interest to Action Initiative sponsored by Association of Maternal and Child Health Programs and National Association of City and County Health Officers to address teen pregnancy and/or teen HIV/STI infection at the local level.

The Colorado legislature passed House Bill 1292, that established standards for local school districts to use when developing comprehensive and medically accurate sex-education curricula.

The Colorado Organization for Adolescent Pregnancy, Parenting, and Prevention (COAPPP) was awarded a two-year grant to provide teen pregnancy prevention health education through school-based health centers at three high-risk schools.

Colorado did not reapply for federal funding for the Title V, Section 510 Abstinence Education Program and the program was discontinued.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Title X and CFPI Family Planning Program clinical services were expanded.	X			
2. Title V MCH funded school based health centers to address high risk behaviors among teens.	X	X	X	
3. MCH provided consultation to local health agencies regarding teen pregnancy prevention.			X	
4. Submitted a Medicaid 1115 Family Planning Waiver to expand services.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target rate for reporting year 2009 is no more than 21.5 births per 1,000 teens age 15 to 17.

The Family Planning Program continued to receive funding from a private foundation to expand clinical services and provide long-term efficacious contraceptives to men and women through the Colorado Family Planning Initiative. This initiative included outreach to teens with the goal of decreasing unintended pregnancies in Colorado. Twenty expansion grants were awarded in January 2009. The Family Planning Program also received expansion funding from Title X to support four new sites.

The Child, Adolescent and School Health Unit continued to participate in work mandated by Colorado House Bill 1292 to establish standards for local school districts to use when developing sex-education curricula. The unit also participated in an Adolescent Sexual Health workgroup with other state departments and communities.

An Action Guide on Teen Pregnancy Prevention was completed and disseminated to assist local agencies. It is at http://www.cdphe.state.co.us/ps/mch/newfiles/ActionGuide_TeenPregnancyPrevention.pdf.

The Colorado Organization for Adolescent Pregnancy, Parenting, and Prevention (COAPPP) began implementing a two-year grant to provide teen pregnancy prevention health education through the school-based health centers at three high-risk schools.

The Women's Health Unit responded to a set of questions from CMS regarding the Medicaid 1115 Family Planning Waiver.

c. Plan for the Coming Year
The target birth rate for reporting year 2010 is 21.0 per 1,000 teenagers aged 15 through 17.

The Women's Health Unit will work closely with the state Medicaid Program if the 1115 Family Planning Waiver is approved to develop and carry out an implementation work plan to increase the number of women and men served in the state.

The Family Planning Program will continue expanding services through Title X and the Colorado Family Planning Initiative. Social marketing approaches to address teen and unintended pregnancy will be used.

Women's Health staff members will remain active in HealthyWomen HealthyBabies, a coalition working to improve birth outcomes in Colorado. Work is underway to enhance access to preconception health information for women of childbearing age as a strategy to improve birth outcomes. This may include development of clinical guidelines with the Colorado Clinical Guidelines Collaborative and subsequent health care provider education. Additionally, many aspects of preconception care are relevant to promoting healthy lifestyles for teens and preventing teen pregnancies.

COAPPP and The National Campaign are sponsoring a statewide conference in October 2009 entitled "Raising the Bar: Putting the Promise to Practice in Adolescent Reproductive Health and Support for Young Families." The conference will include sessions on policy, advocacy, science-based program development and evaluation, sustainability, youth and community development, and health access & delivery. Participation is expected from clinicians, youth development professionals, health educators, and advocates.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	35	35.5	35.5	36	36
Annual Indicator	35.2	35.2	29.3	35	35
Numerator					
Denominator					
Data Source					2006-2007 CO Basic Screening Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	38	40	41	41.5	42

Notes - 2008

Data reported for 2008 are final Basic Screening Survey data from the 2006-2007 school year for a representative sample of 3rd graders. The data repeat the data reported for 2007 since the survey is conducted every three years. That last survey was conducted in 2006-2007 and the next survey should be conducted in 2009-2010.

Notes - 2007
Data reported for 2007 are final Basic Screening Survey data from the 2006-2007 school year for a representative sample of 3rd graders.

Notes - 2006
Data reported for 2006 are preliminary Basic Screening Survey data from the 2006-2007 school year. When finalized, a representative sample of 3rd grades will be covered. Preliminary data were not yet weighted or fully analyzed when these data were submitted in July 2007.

a. Last Year's Accomplishments
The target for reporting year 2008 was 36.0 and it was not met (using school year 2006-2007 data). The annual indicator showed that 35.0 percent of third grade children received protective sealants on at least one permanent molar tooth.

All ten sealant contractors funded by the department applied for and received a Medicaid provider number during the reporting period, resulting in increased funding for the programs. A Seals Efficiency Assessment for Locals and States (SEALS) data system measure does not currently exist to capture how many Medicaid claims were submitted and paid, but a total of nearly $152,000 was reported as received across all contractors for their sealant programs in 2007-2008. According to SEALS data from the same school year nearly 37 percent of sealant program participants were Medicaid recipients and nearly seven percent were enrolled in Child Health Plan Plus. The remaining 58 percent of children were not classified, so it is unclear how many of them were uninsured, but future software upgrades will allow for this capability.

There is little reported data on referrals from school sealant programs that result in dental visits. Providers report that one difficulty in tracking this is the loss to follow-up due to the transient nature of sealant program participants. Some schools in inner city Denver have nearly 100 percent turnover of the classroom in a single school year, resulting in an inability to check for follow-up among the initial group of students.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expanded the school-based sealant program.	X			
2. Provided technical assistance and training regarding sealants.			X	
3. Collected, analyzed and posted oral health information.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The target for reporting year 2009 is for 38.0 percent of third grade children to receive protective sealants on at least one permanent molar tooth.

The Oral Health Unit is completing the data analysis and interpretation on the school sealant program evaluation. Preliminary data show that the program is reaching the appropriate target population as designated by the Centers for Disease Control and Prevention. Nearly 89 percent of children participating in the sealant programs are from schools where more than 50 percent of the students are eligible for free and reduced lunch. Over 300 children received sealants and 2,600 were referred for follow-up dental care.

A total of nine contracts for dental sealant programs were issued in September 2008 for school sealant programs in school year 2008-2009. In 2007-2008 approximately 61 percent of eligible schools statewide received sealant services through this program, screening nearly 5,500 children, with nearly 3,100 children receiving sealants. A total of 9,600 first-molar sealants were placed.

Sealant contractors will continue to receive funding and technical assistance from the Oral Health Unit.

c. Plan for the Coming Year
The target for reporting year 2010 is for 40.0 percent of third grade children to receive protective sealants on at least one permanent molar tooth.

Activities described above will continue.

The Oral Health Unit will revise the sealant expansion plan based on the recommendations and findings from the sealant evaluation. The plan is used to target sealant programming to new areas of the state with identified needs and to improve the Colorado performance measure for sealant prevalence.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	3.3	3	3	3	3
Annual Indicator	4.2	3.4	3.2	3.2	2.7
Numerator	41	33	32	32	28
Denominator	966203	970051	989454	1002764	1019648
Data Source					Death certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	2.5	2.4	2.4	2.3	2.3

Notes - 2008

Data shown for reporting year 2008 are calendar year 2007 data representing deaths from all motor vehicle injuries for children from birth through age 14. The data were retrieved from the Colorado Health Information Dataset (CoHID) at http://www.cdphe.state.co.us/cohid/.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data.

Notes - 2006
Data shown for reporting year 2006 are calendar year 2005 data.

a. Last Year's Accomplishments
The target rate for reporting year 2008 was 3.0 per 100,000 and it was met with a rate of 2.7 (using calendar year 2007 data). There were 28 deaths caused by motor vehicle crashes to children ages 14 years and younger.

Results from the booster seat project in Colorado Springs identified that child care center regulation regarding transportation of children could be strengthened. As part of this project researchers reviewed 40 child care transportation policies and discovered that while many of them discussed requirements for transporting children in center vehicles, only a few of them addressed parents transporting their children to and from child care. The policies that did discuss parents transporting children in vehicles only did so in the context of transporting children to or from field trips. A sample Family Transportation Agreement for child care centers to use with the families they serve was developed. This agreement explained Child Passenger Safety (CPS) laws and stressed best practices for transporting children. It is posted at http://www.cdphe.state.co.us/pp/injuryprevention/CCCFamilyTransportationAgreement.pdf.

Injury, Suicide, Violence Prevention (ISVP) staff assisted the Emergency Medical and Trauma Services (EMTS) Division in promoting their EMS Provider Grant program, which assists private and public organizations to improve and expand the emergency medical services system in Colorado. Although organizations are eligible to apply for funds to conduct injury prevention programs, historically the EMTS Division has not received injury prevention applications. As a result of the ISVP Unit's efforts, two communities submitted successful applications to strengthen their CPS programs. ISVP staff also continued to serve on the state CPS advisory board and helped to promote other local CPS grant opportunities available from the Department of Transportation.

ISVP staff, in conjunction with the Injury Community Planning Group (ICPG), continued to promote seatbelt use for all occupants of motor vehicles. Studies show that when drivers wear seatbelts, the children in the vehicle are more likely to be restrained. The ICPG serves as the advisory board for the Injury Prevention Program and is also a committee of the State Emergency Medical and Trauma Advisory Council (SEMTAC). Each year the ICPG selects recommendations from the Colorado Injury Prevention Strategic Plan to implement. Priorities last year included promoting community grant opportunities for CPS programs. ISVP staff and ICPG workgroups revised the motor vehicle chapter of the State Injury Prevention Strategic Plan to include updated data on motor vehicle-related injuries and a section on evidenced-based practices. The Colorado Injury Prevention Strategic Plan is posted at www.cdphe.state.co.us/pp/injuryprevention/IP_03-08finalstrategicplan.pdf.

The Colorado State Patrol and the Colorado Department of Transportation (CDOT) partnered to conduct focus groups with "tweens" (8-15 year olds) to assist in developing a social marketing campaign to increase seatbelt use in this age group. The focus groups revealed that high tech messages resonate with the tween audience. For example, focus group participants reacted positively to campaign materials that used the slogan "wi click," which is a play on the name of the Nintendo Wii game system.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued training and expansion activities.			X	
2. Work continued with the Colorado Department of Transportation statewide Child Passenger Safety (CPS) program to support training of more Child Passenger Safety Technicians, and to develop local CPS programs.			X	X
3. Developed social marketing campaign.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The ICPG worked with the EMTS Division and SEMTAC to pass a rule change for inclusion of restraint use in the required EMS data submission to the state. This information is often missing in law enforcement reports and could be used to evaluate prevention projects.

The ICPG proposed primary seat belt legislation, as well as legislation to require seatbelts on school buses. It did not pass, but activities led to increased awareness of these issues among stakeholders.

The ISVP Unit continued to support local communities by providing and coordinating technical assistance and developing other resources. Four fact sheets on childhood injury topics, including motor vehicle safety, were developed for distribution through local child passenger safety coalitions.

The Colorado Department of Transportation created a social marketing campaign targeting Hispanic parents. Materials were distributed through several grassroots community coalitions funded by CDOT to improve child passenger safety among Hispanic children.

The CPS Advisory Board worked with the Department of Human Services to propose a rule change to the DHS statutes to strengthen child care center regulations by including updated CPS statute information and requiring child care centers to include the Family Transportation Agreement in their parent handbooks.

The Colorado Child Fatality Prevention State Review Team reviewed the circumstances of 71 cases of motor vehicle deaths that involved children from birth to age 14.

c. Plan for the Coming Year

The target rate for reporting year 2010 is 2.4 per 100,000 deaths caused by motor vehicle crashes to children ages 14 years and younger.

The ISVP Unit and the ICPG will continue to promote seatbelt use for all occupants of motor vehicles and will monitor any seatbelt or CPS legislation, if proposed, for the 2010 legislative session.

ISVP staff will continue to serve as a board member on the State CPS Advisory Board.

The Colorado Child Fatality Prevention State Review Team will conduct comprehensive reviews of motor vehicle death cases that involve children ages 0-14. The team will identify strategies to prevent child motor vehicle deaths and will make recommendations to the Colorado General Assembly in their Annual Legislative Report.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			42	47	43
Annual Indicator		41.5	46.3	42	48.2
Numerator					
Denominator					
Data Source					2007 National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	50	50	50	50	50

Notes - 2008
Data shown for reporting year 2008 are breastfeeding rates collected by the National Immunization Survey for infants born in 2005 (see http://www.cdc.gov/breastfeeding/data/NIS_data/index.htm). These data represent all breastfeeding (not just exclusive breastfeeding) at six months of age. The rate is provisional.

A target of 50 percent is shown for all years, consistent with the Healthy People 2010 goal for breastfeeding at six months.

Notes - 2007
Data shown for 2007 are breastfeeding data collected by the National Immunization Survey for infants born in 2004. This method represents a change from the methodology of previous NIS surveys, where the data pertained to the year the interview occurred -- which was not necessarily the birth year of the infant.

Notes - 2006
Data shown for 2006 are breastfeeding data collected by the National Immunization Survey in 2005.

a. Last Year's Accomplishments
The target for reporting year 2008 was 43.0 percent and it was met (using data from infants born in 2005). The annual indicator showed that 48.2 percent of mothers breastfed their infants at 6 months of age.

However, in spite of WIC Program efforts to support mothers to breastfeed longer, WIC data

show no improvement in breastfeeding duration at 6 months from the rate in 2006 (28.9 percent) to the rate in 2008 (28.1 percent). Breastfeeding at 12 months decreased from 2006 (18.5 percent) to 2008 (17.5 percent).

The Colorado Breastfeeding Coalition, WIC Program, and Colorado Physical Activity and Nutrition Program (COPAN) strengthened their efforts around public and employer education regarding compliance with new legislation. The Workplace Accommodation for Nursing Mothers Act went into effect in August 2008 and supports mothers' efforts to breastfeed longer.

Materials for mothers and employers were developed and disseminated at an employer conference, through local WIC agencies, and on the websites of the Coalition and the Colorado Department of Labor. The Coalition celebrated the passage of the law with local legislators and the community on the steps of the State Capitol to bring media attention to the new law and to increase public awareness. At least two COPAN LiveWell communities worked with employers to support nursing mothers by providing education and resources to develop lactation rooms.

Through a collaborative effort, known as the Colorado Can Do 5! Initiative, the Coalition, WIC and COPAN continued disseminating information statewide on the findings of the 2007 report, "Getting It Right After Delivery: Five Hospital Practices That Support Breastfeeding" at www.cdphe.state.co.us/ps/mch/gettingitright.pdf. The Colorado population-based study identifies five supportive hospital practices that have a significant positive impact on breastfeeding continuation. While each of the five practices independently is linked with a longer duration of breastfeeding, women who experience all five supportive hospital practices have the longest duration of breastfeeding. The report describes that only one in five Colorado mothers of healthy breastfed infants reported experiencing all five successful hospital breastfeeding practices in 2002-2003. COPAN provided trainings to Coalition volunteers who took the messages from the report to the staff at nineteen hospitals in the state. At the completion of each training, the presenter provided a resource kit to the hospital. Similar information about the report and initiative was provided to WIC and public health agencies, Lactation Journal Club attendees, local breastfeeding task forces, and prenatal providers through various methods, primarily in-person presentations. The consumer companion information is summarized on the Colorado Can Do 5! crib cards. The crib cards are available in two colors, Spanish on one side and English on the other. A total 20,000 cards were produced and approximately 15,000 were disseminated to WIC Programs, hospitals, and nurse home visitor programs.

All Colorado hospital administrators were sent CDC's "Breastfeeding Report Card -- United States 2007," with a memo describing strategies, such as adopting specific hospital practices, to improve Colorado's record on the report card of the percent of births occurring at facilities designated as "baby-friendly" (2.07 percent in Colorado). Fifteen states had higher percentages.

The WIC Program continued to build lactation expertise within its programming. Five agencies have a breastfeeding peer counselor program and in August 2008 an additional 97 staff attended a 3-day training to become lactation specialists. From that training, approximately 85 WIC paraprofessional and professional staff became WIC lactation management specialists. The quarterly issues of the Breastfeeding Update newsletter continued to provide another means for educating WIC staff and health care providers statewide.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provided materials for mothers and employers around the Workplace Accommodation for Nursing Mothers Act.			X	
2. Began the the Colorado Can Do 5! initiative to support breastfeed continuation.			X	X

3. Sent the CDC publication, Breastfeeding Report Card, United States 2007 to all Colorado hospital administrators.			X	
4. The WIC Program continued to build lactation expertise within its programming.	X	X	X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The target for reporting year 2009 is 50.0 percent.

Initiatives supporting breastfeeding were continued from last year.

The state health department contracted with Marianne Neifert, MD, to deliver the Colorado Can Do 5! messages to an additional 23 hospitals and communities. Hospitals received tailored presentations for each venue, audience, and specific needs. In addition to the training, each hospital received a breastfeeding practices resource kit and the offer of technical assistance (by telephone) in adopting the five supportive maternity practices at their facility.

Many presentations were provided to a variety of audiences (child care providers, LiveWell, employers, Robert Wood Johnson Foundation Commission for a Healthier America) in an effort to educate about accommodating lactation in the workplace. The Colorado Breastfeeding Coalition, with financial support from a grant from the U.S. Breastfeeding Committee, Medela, Inc, and COPAN reached out to support mothers by developing a working breastfeeding mother role-play video vignette for YouTube.

In June 2009 the Colorado WIC food packages changed to better meet the nutritional needs of WIC participants by aligning with the 2005 Dietary Guidelines for Americans and infant feeding practice guidelines of the American Academy of Pediatrics. The Program's new food packages step up efforts to promote and support breastfeeding and provide a greater variety of foods.

A breastfeeding logic model was developed (attached).
An attachment is included in this section.

c. Plan for the Coming Year
The target for reporting year 2010 is for 50.0 percent of mothers to breastfeed their infants at 6 months of age.

Eighty-four percent of Colorado hospitals are expected to become familiar with the Colorado Can Do 5! initiative. All Colorado hospitals will be surveyed on their maternity care practices. Hospitals with policies, procedures and other documentation that demonstrates that they have institutionalized the five practices will receive awards and be given public recognition. Using PRAMS data, Colorado will also be able to evaluate this initiative by comparing mothers' responses about their experiences in the hospitals during the years 2008-2009 to those collected for 2002-2003.

Also during this year, the Coalition will be urging hospitals to discontinue providing formula gift bags to breastfed infants. Presently, there are five out of 55 hospitals in Colorado that do not provide discharge bags containing formula to breastfeeding mothers.

The CDPHE will have a centralized breastfeeding page on its website. There will be at least two

breastfeeding training opportunities to increase the competency of WIC and non-WIC health care providers.

COPAN will continue to educate employers on the benefits of supporting nursing mothers in the workplace and will offer mini-grants ($2,000) to ten communities to reach out to at least five employers to develop supportive lactation programs for employees.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	95	98	98	98	98
Annual Indicator	97.2	97.5	97.5	97.6	97.2
Numerator	67329	66769	66912	68282	68088
Denominator	69304	68475	68660	69939	70082
Data Source					Newborn Hearing Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	98	98	98	98	98

Notes - 2008
Data shown for reporting year 2008 are calendar year 2007 data.

The numerator is the number of newborns, born to Colorado residents who delivered in Colorado, that underwent newborn hearing screening at birth. The denominator is the number of live births to Colorado residents who gave birth in Colorado. (The denominator is smaller than the total number of births to Colorado residents by the number of residents who gave birth out of state.)

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data.

The numerator is the number of newborns that underwent the newborn hearing screening at birth who were born to Colorado residents who delivered in Colorado. The denominator is the number of live births to Colorado residents who gave birth in Colorado. (The denominator is smaller than the total number of births to Colorado residents by the number of residents who gave birth out-of-state.)

Notes - 2006
Data shown for reporting year 2006 are calendar year 2005 data.

The numerator is the number of newborns that underwent the newborn hearing screening at birth who were born to Colorado residents who delivered in Colorado. The denominator is the number of live births to Colorado residents who gave birth in Colorado. (The denominator is smaller than the total number of births to Colorado residents by the number of residents who gave birth out-of-state.)

a. Last Year's Accomplishments
The reporting year 2008 target was 98.0 percent and it was not met (using 2007 calendar year data). A total of 68,088 newborns were screened for hearing before hospital discharge.

Multidisciplinary Early Hearing Detection and Intervention (EDHI) Teams were established in half of the state and are in various stages of development in the rest of Colorado. The teams consist of professional and lay community members involved with newborn screening. They provide training and support for each birthing hospital and identify and address potential gaps in service specific to each community.

Last year's goal of training staff at one hospital to begin entering screening and audiologic diagnostic information directly into the Newborn Evaluation, Screening and Testing/Clinical Health Information Records of Patients (NEST/CHIRP) database system was met. The success of the pilot was an important step toward the ongoing goal of data integration.

An increase in cooperation among the Newborn Hearing Screening Follow-Up Program, the Newborn Metabolic Screening Follow-Up Program and the state laboratory was successful and led to birth certificate data being used to facilitate follow-up of children at risk. Laboratory data, birth certificate data, newborn hearing screening data and newborn metabolic screening data were integrated into a single database so all results can be found for an individual child.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Multidisciplinary early hearing detection and intervention (EDHI) Teams were established.			X	
2. One hospital engaged in direct entry of screening and audiologic diagnostic information directly into the Newborn Evaluation, Screening and Testing/Clinical Health Information Records of Patients (NEST/CHIRP) database system.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The target for reporting year 2009 is for 98.0 percent of newborns to be screened for hearing before hospital discharge.

Colorado participated in the National Initiative for Children's Healthcare Quality (NICHQ) learning

collaborative. It provided a unique opportunity to share, test and implement ideas for more timely, appropriate, coordinated and family-centered care for children identified with hearing loss.

EHDI staff were more available to provide technical assistance across the state. Staff visited half of the state's birthing hospitals to provide technical assistance and support to individual hospitals in conjunction with the formation of the regional EHDI Teams. Staff provided technical assistance upon request by teleconference.

Under the guidance of the state EHDI program and the Colorado chapter of Hands & Voices (a parent-driven support group for families of children who are deaf and hard of hearing), each of the regional EHDI teams is developing a Road Map for parents and providers that identifies resources specific to the community and outlining next steps for families whose infants fail or miss an initial test. The general template for the Road Map is complete and will be disseminated to regional teams to individualize for their communities.

c. Plan for the Coming Year
The target for reporting year 2010 is for 98.0 percent of newborns to be screened for hearing before hospital discharge.

The Colorado Infant Hearing Advisory Committee Guidelines for Infant Hearing Screening, Audiologic Assessment and Early Intervention will be revised and updated according to the Joint Committee on Infant Hearing's 2007 position statement. This detailed document includes guidelines for physicians, parents, early interventionists and audiologists. It also includes recommendations for screening technologies, infant audiologic assessment and pediatric amplification, as well as guidelines for early intervention services.

Development of the web-based database system, that will convert the current NEST/CHIRP system from a Citrix-based system to a Web-based system, continues to be the priority of the EHDI Program's Information Technology Unit. The conversion completion date is targeted for January 2010. This improvement will allow easier access by all CHIRP users and will enable more hospitals and audiologists to securely access and input newborn screening and diagnostic data directly into the database.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	15	15	10	9	10
Annual Indicator	14.3	12.6	11.9	10.3	8.2
Numerator	176328				
Denominator	1233064				
Data Source					Colorado Child Health Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**

Annual Performance Objective	8	8	7	7	6

Notes - 2008
Data shown for reporting year 2008 are calendar year 2008 Colorado Child Health Survey Data. The percentage includes children age 1-14 uninsured at the time of the survey.

Notes - 2007
Data shown for 2007 are calendar year 2007 Colorado Child Health Survey data. The percentage includes children age 1-14 uninsured at the time of the survey.

Notes - 2006
Data shown for 2006 are calendar year 2006 Colorado Child Health Survey data. The percentage includes children age 1-14 uninsured at the time of the survey.

a. Last Year's Accomplishments
The target for reporting year 2008 was 10.0 percent and it was met (using calendar year 2008 data). The annual indicator showed 8.2 percent of children without health insurance. Recent expansions in Child Health Plan Plus eligibility may well have contributed to the decline.

Based on legislation passed in the 2007 Colorado legislative session, MCH worked closely with the Colorado Department of Health Care Policy and Financing, through the Medical Home Initiative, to develop state accepted standards for a medical home. In addition to key state agency representation, the Medical Home Initiative Advisory Board includes, but is not limited to, participation from the Colorado Chapter of the American Academy of Pediatrics, the Colorado Academy of Family Physicians, family representatives, mental health and oral health representatives.

Several local agencies have access to care as a priority area. MCH created an Access to Care Workgroup with local public health MCH contractors and state staff to explore the outcome of local health departments' efforts to address access to care at the enabling services level (e.g., the provision of individual presumptive eligibility certification services). The group also began efforts to identify access to care interventions that are employed at the infrastructure building versus the enabling service level that might impact access at the systems level.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCH created an Access to Care Workgroup with local public health MCH and state staff.				X
2. Develop state accepted standards for a medical home.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The target for reporting year 2009 is for no more than 8.0 percent of children to be without health insurance.

The MCH Access to Care Workgroup continued to meet. A summary was developed of the access to care issues and challenges experienced by local health departments who serve MCH populations. A major focus of this group was to examine systems building efforts and identify other partners for this work.

An Evaluation Subcommittee was formed to examine the efficacy of local public health efforts to facilitate enrollment of children into Medicaid.

The Women's Health Unit initiated a Local Health Agency and Medicaid Workgroup to facilitate communication and greater partnership between the local health agencies and Medicaid, as they work together to provide adequate and early care to pregnant women and children (under 19) on Medicaid. The workgroup met monthly to share information and discuss solutions regarding changes in the Medicaid system, available resources, and barriers that impact prenatal and child health care.

The Colorado Healthcare Affordability Act passed. This new law created a hospital provider fee which will be used to increase access to Medicaid for low income adults and expand Child Health Plan Plus eligibility to 250 percent of the federal poverty level.

c. Plan for the Coming Year

The target for reporting year 2010 is for no more than 8.0 percent of children to be without health insurance.

Activities described above will continue.

The MCH Access to Care Workgroup will continue to examine the role of MCH in access to care by analyzing the outcomes of the evaluation subcommittees' work.

The MCH Access to Care Subcommittee will implement a telephone survey with presumptive eligibility clients served by local public health to assess the impact of these activities. This survey will examine Medicaid eligibility and first trimester enrollment rates of clients.

The Epidemiology, Planning and Evaluation Branch will implement a social network analysis with local health departments participating in the subcommittee to assess county level Medicaid enrollment systems and collaboration between partners.

The Local Agency Medicaid Workgroup will meet monthly to facilitate communication and greater partnership between the local health agencies and the state Medicaid Program.

The Colorado Healthcare Affordability Act created a hospital provider fee that will generate an estimated $600 million in revenue. This revenue will be matched by the federal government yielding a total of $1.2 billion that will help reimburse providers for uncompensated care and will allow Colorado to expand Medicaid to parents and single adults up to 100 percent of the federal poverty level, to expand Child Health Plan Plus to children up to 250 percent of federal poverty level, to create a Medicaid buy-in program for the people with disabilities, and to institute continuous 12-month enrollment.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			24	24	24
Annual Indicator		24.2	24.7	24.3	24.3
Numerator		8739	8832	9018	9825
Denominator		36113	35758	37111	40432
Data Source					2007 Pediatric Nutrition Surveillance
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	23	23	23	23	23

Notes - 2008
Data shown for 2008 are from the 2007 Pediatric Nutrition Survey. This can be accessed on the WIC website at: http://www.cdphe.co.us/ps/wic/nutritionsurveillance/nutritionsurveillance.html.

Notes - 2007
Data shown for 2007 are from the 2006 Pediatric Nutrition Survey.

Notes - 2006
Data shown for 2006 are from the 2005 Pediatric Nutrition Survey.

a. Last Year's Accomplishments
The target for reporting year 2008 was 24.0 percent and it was nearly met (using 2007 data). A total of 9,825 children ages 2 to 5 years out of 40,432 who received WIC services had a Body Mass Index at or above the 85th percentile.

The Colorado WIC Program conducted a WIC Participant Satisfaction Survey in Spanish and English that asked participants questions regarding their own assessment of their child's weight. Survey summary reports were provided in April 2008 to agencies for use in future planning. A high percentage of participants reported making a change in their diet (increased fruits and vegetables) and habits (decreased soda intake) through WIC counseling and are interested in establishing good habits in their children.

WIC implemented new policies and provided training to enhance the competency of staff in conducting participant-centered WIC visits. These efforts enhanced staff's effectiveness when discussing sensitive topics such as weight. Regional workshops addressed participant-centered nutrition assessment, counseling and goal setting. These trainings offered examples of assessment, counseling and goal setting strategies to use with overweight WIC participants.

WIC Program Staff participated in the Colorado Physical Activity and Nutrition (COPAN) Early Childhood Taskforce and the Breastfeeding Coalition, both of which addressed childhood obesity.

USDA issued the final interim rule for WIC food packages revisions. The State WIC Office planned for the implementation of the revised WIC food package and new nutrition education messages.

A staff position was created to coordinate breastfeeding promotion and support activities across the WIC, COPAN, and MCH Programs.

A position paper, The Role of the Colorado WIC Program in the Prevention of Maternal and Pediatric Overweight and Obesity, was developed.

WIC hosted a Pediatric Update videoconference sponsored by University of Alabama at Birmingham for local agency WIC staff. It provided information on assessment and treatment of overweight children and discussed food marketing to children.

Three articles or inserts were included in the Colorado WIC News relating to overweight prevention. The WIC News is sent to all local agency WIC staff.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Regional workshops addressed nutrition assessment, counseling and goal setting strategies to use with WIC participants.			X	
2. Staff position created to coordinate breastfeeding promotion and support activities across WIC, COPAN and MCH.				X
3. Continued to work with COPAN and others to address the obesity issue.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2009 is 23.0 percent.

Prevention of overweight is one of two statewide health outcome goals that are included in Colorado WIC's Nutrition Education Plan. Each local WIC agency assists in achieving the statewide goal by implementing community-specific action plans targeting overweight prevention and breastfeeding promotion. The nutrition education planning process includes: conducting a needs assessment; developing an action plan that includes evaluation activities; and reporting these activities to the state office.

WIC staff collaborated with other state programs (Child and Adult Care Food Program, Maternal and Child Health, and COPAN) to review and discuss the state Early Childhood Obesity Prevention Environmental Scan. Metropolitan State College conducted an environmental scan of early childhood (age 0-5 years) obesity prevention programs and initiatives in Colorado and provided recommendations to support child care provider obesity prevention efforts.

Colorado began implementing the new food package rule on June 1, 2009. These food package changes include the addition of fresh fruits and vegetables; reduction in the amount of juice given to children and no juice to infants; and inclusion of whole grains. These positive changes will complement WIC's ongoing message about healthy eating and the importance of breastfeeding.

c. Plan for the Coming Year
The target for reporting year 2010 is for no more than 23.0 percent of children ages 2 to 5 years receiving WIC services to have a Body Mass Index at or above the 85th percentile.

Prevention of overweight will continue to be one of two statewide health outcome goals that are included in Colorado WIC's Nutrition Education Plan.

WIC will host the 2010 Annual State WIC Meeting that will include a wide variety of presentations to improve local staff understanding of the childhood overweight problem, as well as their competencies as nutrition counselors.

WIC will host the National Maternal Nutrition Intensive Course videoconference from the University of Minnesota for local WIC agency and state staff during the fall of 2009. This program focuses on the improvement of maternal and infant health through the delivery of risk-appropriate high-quality nutrition services.

The state WIC Office will collaborate with local WIC agencies, COPAN, and other Prevention Services Division programs to develop and deliver consistent messages regarding childhood overweight prevention.

A staff position to address childhood overweight issues across the WIC, COPAN, and MCH Programs is being considered. If created, this position will coordinate efforts across the department to enhance healthy weight among children.

WIC's role in the prevention of childhood overweight will be defined and ways to use additional resources, should they become available, to fulfill or extend that role will be identified.

The position paper, The Role of the Colorado WIC Program in the Prevention of Maternal and Pediatric Overweight and Obesity, will be updated.

Three articles or inserts will be included in the Colorado WIC News relating to overweight prevention.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			10	9	10
Annual Indicator		10.4	10.2	10.4	10.8
Numerator					
Denominator					
Data Source					Pregnancy Risk Assessment Monitoring System
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore					

a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	10	10	9	9	8

Notes - 2008
Data for reporting year 2008 are from 2007 Pregnancy Risk Assessment Monitoring System (PRAMS) data.

Notes - 2007
Data for reporting year 2007 are from 2006 Pregnancy Risk Assessment Monitoring System (PRAMS) data.

Notes - 2006
Data for reporting year 2006 are from 2005 Pregnancy Risk Assessment Monitoring System (PRAMS) data.

a. Last Year's Accomplishments
The target for reporting year 2008 was 10.0 percent and it was not met (using calendar year 2007 data). The annual indicator showed that 10.8 percent of women smoked in the last three months of pregnancy.

Prenatal smoking cessation strategies were incorporated with appropriate weight gain strategies into an MCH Healthy Baby Action Guide. Logic models for the Healthy Baby Campaign and Preconception Care were also developed.

Three trainings for MCH local agencies and community health care providers were conducted. To assist with the implementation of the Healthy Baby Campaign, each local agency received a User Guide and Tool Box DVD.

Ten local health agencies used Healthy Baby campaign strategies in their MCH program plans.

An external advisory group was formed to strengthen prenatal smoking cessation messages. The Colorado Clinical Guidelines Collaborative (CCGC), State Tobacco Education and Prevention Partnership (STEPP), and the Women's Health Unit led the organizational efforts. The panel developed a consensus statement and messaging specific to prenatal smoking cessation. CCGC, STEPP and Women's Health staff, using STEPP funding, began drafting evidence-based prenatal smoking cessation clinical guidelines. A division-wide prenatal smoking cessation project team was convened to address prenatal smoking cessation among WIC, STEPP, Prenatal Plus and Nurse Home Visitor Programs. A member of the Women's Health Unit led the project team.

The STEPP grant process continued to fund outreach to women of reproductive age. Prenatal smoking cessation brochures, posters and a resource packet for pregnant women that contains information and resources was developed. Smoking cessation kits were distributed in public health and safety net clinics statewide. STEPP continued statewide media and website campaigns targeting adolescents (12-18 year olds) and young adults (19-25 year olds). The STEPP "Own Your C" media campaign, QuitLine resources and indoor smoking ban in Colorado remain helpful deterrents to smoking for women before, during and after pregnancy. A STEPP-funded smoking cessation website (www.fixnixer.com) offered tips and tools to help smokers quit within 21 days. The site services are free and offer a community forum, personal QuitBlog, and personalized text messaging to participants. The Colorado QuitLine provided telephone coaching services and free nicotine replacement therapy, with a doctor's prescription, to Colorado residents calling into the phone line.

The Baby and Me Tobacco Free program secured three years of funding from the Colorado

Health Foundation. The program provided vouchers for free diapers to low-income women who completed smoking cessation classes and who also participated in carbon dioxide monitoring during pregnancy and up to one year postpartum. The program expanded from one pilot site to 18 sites.

WIC, Nurse Home Visitor, Prenatal Plus and Family Planning programs continued prenatal smoking cessation efforts using the 5 A's smoking cessation counseling model (Ask, Advise, Assess, Assist, Arrange).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Developed the Healthy Baby Action Guide & Logic Model.				X
2. A resource disk user guide and toolbox were distributed to local agencies to assist with implementation of the Healthy Baby Campaign.				X
3. Ten Local Health Agencies used Healthy Baby strategies in MCH program plans.	X	X	X	X
4. CCGC, STEPP and Women's Health staff began drafting evidence-based prenatal smoking cessation clinical guidelines.				X
5. Baby and Me Tobacco Free expanded to 18 sites statewide.	X	X		
6. STEPP outreach/marketing campaign continued.				X
7.				
8.				
9.				
10.				

b. Current Activities
The target for reporting year 2009 is 10.0 percent.

The Colorado Department of Public Health and Environment includes decreasing the use of tobacco products as a direction in the FY 2008-2009 Strategic Plan and specifically addresses prenatal smoking cessation.

Six of 14 community-level MCH plans have incorporated prenatal smoking cessation messages with appropriate weight gain recommendations to help reduce Colorado's low birthweight rate. The Healthy Baby Action Guide and additional Healthy Baby resources are available from the Women's Health and Healthy Baby websites at www.healthy-baby.org.

The Colorado Health Foundation (CHF) funds Baby and Me Tobacco Free program until October 31, 2009. The program is expanding from 18 to 23 sites within Colorado.

The CCGC and STEPP have updated general tobacco cessation clinical guidelines. Corollary prenatal smoking cessation guidelines are in the draft stage and will be disseminated statewide.

The fixnixer website continued activities.

The Prenatal Smoking Cessation Project Team, led by a staff member from Women's Health Unit, is working to expand the types of health care professionals beyond behavior specialists who are reimbursed by Medicaid for providing the 5 A's smoking cessation counseling.

STEPP funding was used to support prenatal smoking cessation efforts to assist providers to

strengthen their smoking cessation counseling skills. A web-based training using the 5 A's model is being developed.

c. Plan for the Coming Year
The target for reporting year 2010 is for no more than 10.0 percent of women to be smoking in the last three months of pregnancy.

Six of 14 community-level MCH plans will include prenatal smoking cessation projects combined with appropriate maternal weight gain recommendations to help reduce Colorado's low birthweight rate. The Healthy Baby website will expand smoking prevention and cessation information and resources for providers and consumers.

The Baby and Me Tobacco Free program will continue activities from the previous year in at least 23 sites statewide. The Colorado Health Foundation will continue to fund expansion of the program until October. A second grant request to CHF for two more years of funding will be developed. Funding beyond 2011 will support continuing the provision of diaper vouchers statewide.

CCGC and STEPP will finalize prenatal smoking cessation clinical guidelines. These will be disseminated to Colorado providers who care for women of reproductive age. The Prenatal Smoking Cessation Project Team, led by a Women's Health Unit staff member, is working to expand the types of health care professionals beyond behavior specialists who are reimbursed by Medicaid for providing the 5 A's smoking cessation counseling.

The team will revitalize the prenatal smoking cessation marketing campaign. The campaign will include web-based training for providers to strengthen their smoking cessation counseling skills. Media materials targeting pregnant women and their families will be updated.

The STEPP funded fixnixer website will continue.

Family Planning, Nurse Home Visitor, Prenatal Plus, and WIC programs will continue prenatal smoking cessation efforts to clients statewide.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	12.5	12	11.5	11	10.5
Annual Indicator	7.3	13.7	14.6	10.8	9.5
Numerator	25	47	51	38	34
Denominator	341560	342486	348573	352852	358249
Data Source					Death certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot					

be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	9.5	9.5	9	8.5	8

Notes - 2008
Data shown for reporting year 2008 are calendar year 2007 data representing suicide deaths for youth age 15 through 19. The data were retrieved from the Colorado Health Information Dataset (CoHID) at http://www.cdphe.state.co.us/cohid/.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data.

Notes - 2006
Data shown for reporting year 2006 are calendar year 2005 data.

a. Last Year's Accomplishments
The target for reporting year 2008 was 10.5 per 100,000 and and it was met (using calendar year 2007 data). There were 34 suicide deaths among youths aged 15 through 19.

Suicide remained the second leading cause of death among youth ages 10-24 in Colorado. Based on death certificate data from 1998-2007, the ten-year annual average suicide rate for young adults ages 15-19 in Colorado was 12.1 per 100,000, more than twice the Healthy People 2010 goal of 5.0 per 100,000 for all ages. Ten of Colorado's 64 counties have a youth suicide rate that is statistically higher than the 2002 national rate of 6.9 per 100,000.

The Office of Suicide Prevention provided more than 18,000 pieces of public awareness materials regarding suicide and suicide prevention to individuals and organizations in every region of the state. The office, in partnership with the Suicide Prevention Coalition of Colorado, held three town hall meetings to foster strong collaboration and coordination with local suicide prevention efforts. Meetings were held for interested residents in Montrose, Fremont and Las Animas counties. Youth suicide prevention was a component of discussion at each town hall meeting.

Grants were provided from the Office of Suicide Prevention to ten local agencies for suicide prevention and education services. Local grantees used funds for a variety of youth-focused activities including increasing community awareness of suicide prevention resources; community coalition development; suicide prevention programming at Regis University in Denver; suicide prevention training for Native Americans and Native American youth; and suicide prevention for adults working with gay, lesbian, bisexual, transgender and questioning youth.

The office provided financial support for infrastructure and data collection to the 1-800-273-TALK crisis line, and to the Suicide Prevention Coalition of Colorado to conduct regional town hall meetings, public awareness campaigns, and advocacy training. The Office provided funding to five counties and to the University of Colorado at Boulder through a grant from the Substance Abuse and Mental Health Services Administration for state-sponsored youth suicide prevention and intervention. The project, entitled Project Safety Net, targeted youth in the juvenile justice and child welfare systems by training adults who work in those systems to recognize and intervene with suicidal youth and refer them to life saving services. Project Safety Net also developed an awareness campaign, entitled Start the Conversation that included a website, posters, stickers, buttons and an informational brochure in English and Spanish.

The Office of Suicide Prevention strengthened key private and public partnerships through participation on statewide committees including the Colorado Child Fatality Prevention Systems; the Injury Community Planning Group; the Colorado Violent Death Reporting System Advisory Committee; the Violence Prevention Advisory Group; and the Interagency School Health Team. These partnerships resulted in the coordination of prevention recommendations, data collection,

and service delivery from state agencies.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distributed materials statewide.		X		
2. Provided grants to ten local agencies for suicide prevention and education services.	X	X	X	X
3. Supported a crisis line.	X	X		
4. Conducted regional town hall meetings, public awareness campaigns, and advocacy training.			X	
5. Participated in relevant statewide coalitions.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2009 is for no more than 9.5 suicide deaths per 100,000 youth age 15 through 19.

State funding of $283,000 was allocated for suicide prevention programs statewide. Activities included planning and sponsoring the Bridging the Divide: Suicide Awareness and Prevention Summit at Regis University in May. The summit included participants from throughout Colorado and nationally. Several nationally renowned suicide prevention experts presented at the conference.

The Office also helped organize and sponsor the Suicide Prevention Coalition of Colorado's Prisms of the Heart event attended by more than 200 people. The Office worked with The Colorado Trust, Mental Health America of Colorado, and the Suicide Prevention Coalition of Colorado to write and release a new statewide strategic plan for suicide prevention, Preventing Suicide in Colorado, in April 2009.

Other activities accomplished included a public awareness campaign directed to teens that encourages asking for help for themselves or for friends in suicidal crises; suicide prevention efforts in five Colorado counties and at the University of Colorado at Boulder (Project Safety Net); an elementary emotional wellness and suicide prevention curriculum with the Yellow Ribbon school-based suicide program; ensuring that the 1-800-273-TALK crisis hotline is operational 24 hours per day, seven days per week; and continuing to disseminate community grants dedicated to suicide prevention across the state.

c. Plan for the Coming Year

The target for reporting year 2010 is for no more than 9.5 suicide deaths per 100,000 youth age 15 through 19.

Activities will continue from the previous year.

The Office applied for an additional three years of funding from the Substance Abuse and Mental Health Services Administration to expand youth suicide prevention programs and services through Project Safety Net. If awarded, the project will begin in October 2009.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	75	75	80	83	85
Annual Indicator	73.5	71.9	68.6	81.4	80.5
Numerator	666	639	619	725	749
Denominator	906	889	902	891	930
Data Source					Birth certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	83	85	88	90	90

Notes - 2008
Data shown for reporting year 2008 represent calendar year 2007 data. The denominator represents very low birthweight births to Colorado residents.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data.

Notes - 2006
Data shown for reporting year 2006 are calendar year 2005 data.

a. Last Year's Accomplishments
The target for reporting year 2008 was 85.0 percent and it was not met (using calendar year 2007 data). There were 749 very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Recommendations were made for uniform definitions of levels of care in the American Academy of Pediatrics guidelines concerning levels of neonatal intensive care (November 2004). The definitions were based on a facility's ability to provide increasingly complex levels of care. In particular, distinctions were made between Level II specialty care and Level III subspecialty care. Level II facilities are now divided into two sublevels: IIA and IIB. In IIA facilities, care can be provided to infants born at greater than 32 weeks gestation and weighing more than 1500 grams. In addition to the care provided in IIA facilities, IIB facilities can provide mechanical ventilation for brief durations. Level III facilities are now divided into three sublevels: IIIA, IIIB, and IIIC. IIIA facilities can provide comprehensive care for infants born at more than 28 weeks gestation and weighing more than 1000 grams. IIIB facilities can provide care to infants at 28 weeks gestation or less and weighing 1000 grams or less. IIIC facilities can provide care to all infants, and have additional capabilities to provide extracorporeal membrane oxygenation (ECMO) and surgical repair of serious congenital cardiac malformations that require cardiopulmonary bypass. The distinctions between Level IIB and Level IIIA are especially important in terms of providing care to very low birth weight infants under this performance measure.

During 2005 and 2006, the Colorado Perinatal Care Council revised the hospital self-assessment tool to reflect the new guidelines and began the process of encouraging hospitals to reassess their nurseries. These new designations took effect in January 2006. By the end of 2006, many hospitals had submitted assessments that changed their status from Level II to Level III. As of November 2006, a total of 17 hospitals where births occur were Level III, of which eight were Level IIIA, seven were Level IIIB, and two were Level IIIC. Prior to the change only eight hospitals were Level III.

The data collected for 2007 (reported in 2008 at 80.5 percent) reflects an increase in the percent of very low birth weight infants delivered at facilities appropriate for high-risk deliveries and neonates, designated as Level III. This improvement can be attributed more to the number of former Level II hospitals upgrading their facilities to provide care more appropriately for very low birth weight infants than to any change in referral patterns away from originally Level II facilities to Level III facilities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitored data associated with this measure.				X
2. Participated in the Perinatal Care Council.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The target for reporting year 2009 is for 83.0 percent of very low birth weight infants to be delivered at facilities for high-risk deliveries and neonates.

The Women's Health Unit continues to review this measure and monitor ways to increase the proportion of very low birth weight infants born in appropriate facilities. The Unit has representation on the Colorado Perinatal Care Council, a statewide advisory group committed to improving perinatal care in Colorado. The liaison from the Women's Health Unit participated in the Colorado Perinatal Care Council and engaged in information sharing, interaction and collaboration with other members.

c. Plan for the Coming Year
The target for reporting year 2010 is for 85.0 percent of very low birth weight infants be delivered at facilities for high-risk deliveries and neonates.

Staff will continue to monitor this measure.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Performance Objective	85	83	83	84	84
Annual Indicator	79.3	80.2	80.1	79.7	78.1
Numerator	54117	53955	54147	55354	53828
Denominator	68255	67251	67639	69430	68957
Data Source					Birth certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	82	83	84	85	85

Notes - 2008
Data shown for reporting year 2008 are calendar year 2007 data. The number of pregnant women whose onset of prenatal care is unknown have been excluded. Data were obtained from the Colorado Health Information Dataset (CoHID) at http://www.cdphe.state.co.us/cohid/index.html.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data. Number of pregnant women whose onset of prenatal care is unknown have been excluded.

Notes - 2006
Data shown for reporting year 2006 are calendar year 2005 data. Number of pregnant women whose onset of prenatal care is unknown have been excluded.

a. Last Year's Accomplishments
The target for reporting year 2008 was 84.0 percent and it was not met. The percentge of women receiving first trimester care continued to fall short of the targets just as it had in previous years.

The Learning Communities Forum examined innovative and evidence-based approaches to preconception and prenatal care. The group continued to explore and discuss the challenges experienced by low-income women in accessing first trimester prenatal care across the state.

The group provided three web conferences and presentations to the medical, public health and health care financing communities to enhance communication on promising and evidence-based approaches. Conference topics included Health Care Systems Quality Improvement Program developed by the Los Angeles (LA) Best Babies Network, The Baby and Me Tobacco Free smoking cessation program that targets pregnant and post-partum women, as well as an update on Perinatal Health Data provided by the MCH Demographer.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitored and reviewed factors associated with the measure.			X	
2. The Learning Community on First Trimester Care continued meeting.				X
3. The MCH Access to Care State and Local Workgroup was				X

initiated.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The 2009 target is 82.0 percent.

The MCH program initiated an Access to Care State and Local Planning Workgroup. The workgroup's goal is to examine existing enabling service strategies and to build support for systems building and community mobilization strategies. The results will provide the basis for a future MCH Action Guide on health care access that will be used to frame future efforts in this area at the state and local level.

The Access to Care Workgroup examined access to care initiatives in the state. An Evaluation Subcommittee was formed to examine first trimester enrollment rates for women served by MCH-funded presumptive eligibility services in local public health departments to determine the efficacy of providing assistance with Medicaid eligibility and application completion at the enabling service level. The subcommittee developed a pilot telephone survey to find out if pregnant women with presumptive eligibility determinations qualified for Medicaid and found a health care provider. The survey was piloted from April to July 2009. The results will be reviewed in late summer and the survey will be revised for implementation in the coming year.

The Unit initiated a Local Health Agency and Medicaid Workgroup to facilitate communication and improve partnership between local health agencies and the state Medicaid program. The goal is to improve access to adequate and early care for pregnant women as well as services to children 19 and younger enrolled in Medicaid

c. Plan for the Coming Year
The target for reporting year 2010 is for 83.0 percent of infants born to pregnant women to receive prenatal care beginning in the first trimester.

The MCH Access to Care Workgroup will continue to examine the role of MCH in this area. Quarterly meetings will be held to share information and engage in collaborative efforts.

The MCH Access to Care Subcommittee will carry out a telephone survey with clients receiving presumptive determinations at local public health to assess the efficacy of providing such services in the community.

The department's Epidemiology, Planning and Evaluation Branch will implement a social network analysis with local health departments participating in the MCH Access to Care Subcommittee. The analysis will assess the level of collaboration among county agencies involved in these efforts.

The Local Agency Medicaid Workgroup will meet monthly to facilitate communication and greater partnership between the local health agencies and state Medicaid program.

D. State Performance Measures

State Performance Measure 1: *The proportion of children and adolescents attending public schools who have access to basic preventive and primary, physical and behavioral health services through school-based health centers*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	9.5	11.5	12	12.5	13
Annual Indicator	11.0	10.9	12.4	22.2	6.9
Numerator	83668	83139	96907	176643	55535
Denominator	757668	766236	780708	794026	802639
Data Source					Colorado School-Based Health Center Initiative
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	7	7.2	7.4	7.6	7.8

Notes - 2008
Data shown for reporting year 2008 are based on Fall 2007 public school enrollment data from the Colorado Department of Education. The numerator includes ONLY students in schools with an ON-SITE school-based health center. A total of 39 schools had an on-site school-based health center in the fall of 2007.

Notes - 2007
Data shown for reporting year 2007 are based on Fall 2006 school enrollment data. The numerator includes students in schools with school-linked or on-site school-based health centers.

Notes - 2006
Data shown for reporting year 2006 are based on Fall 2005 school enrollment data. The numerator includes students in schools with school-linked or on-site school-based health centers.

a. Last Year's Accomplishments
The target for reporting year 2008 was 13.0 percent; 6.9 percent was achieved (using data from October 2007). The target was not met. However, the percentage shown for reporting year 2008 represents access to on-site school-based health centers only, while the original target was for on-site and linked access. On-site health services were available to 55,535 out of 802,639 children and adolescents in public schools in Colorado.

During the 2007-08 school year there were 42 school-based health centers. Additionally, a mobile van program served eleven schools and provided individualized dental health, sports physical and immunization clinics to urban and rural schools upon request.

School-based health centers were located in 15 of Colorado's 64 counties and provided preventive and primary physical and behavioral health services to 26,650 unduplicated users, generating 80,408 student visits. Of these visits, 21 percent were for behavioral health care alone.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Planned for distribution of State General Fund dollars available in next fiscal year.			X	X
2. Issued a Request for Applications to school districts to plan school-based health centers in their communities.			X	X
3. Issued a Request for Applications to school-districts to apply for both start-up and implementation funding.			X	X
4. Participated on the advisory council for a local foundation seeking input on a School-Based Health Center Initiative.				X
5. Participated on a taskforce charged with assessing how school health services (including school-based health) can be improved throughout the State of Colorado.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2009 is for 7.0 percent of children and adolescents attending public schools to have access to basic preventive and primary, physical and behavioral health services through on-site school-based health centers.

By the fall of 2009, three new school-based health centers will open, increasing the total number of centers to 45 in 18 of the 64 Colorado counties.

Based upon projections for a significant increase in foundation funding for the planning and start-up of school-based health centers, the School-Based Health Center Program redirected its focus to support existing school-based health centers.

A Request for Applications (RFA) was released on March 16, 2009, soliciting applications from the five school-based health center programs not currently receiving funding through the School-Based Health Center Program; two programs applied and one was chosen to receive funding. Additionally, fifteen programs were invited to apply for contract renewals for the 2009-10 school year. One program requested an extension of their award for planning a new school-based health center. Seventeen awards totaling over $1.4 million will be distributed over the 2009-10 school year.

c. Plan for the Coming Year

The target for reporting year 2010 is for 7.2 percent of children and adolescents attending public schools to have access to basic preventive and primary, physical and behavioral health services through on-site school-based health centers.

Current activities described above will continue.

It is anticipated that four new sites will open in the fall. The 2010 SBHC goal to increase the number of sites by 40 percent from 36 to 50 will likely be surpassed.

The School-Based Health Center Program will convene a group of administrators, funders and leaders with an interest in sthis area to develop school-based health center standards for Colorado. It is hoped that standards will improve child health status by advancing the quality of

services provided in school-based health centers and provide an opportunity for improved payer reimbursement, especially through Medicaid and Child Health Plan Plus.

State Performance Measure 2: *Percent of Medicaid-eligible children who receive dental services as part of their comprehensive services*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	26	35	36	31	32
Annual Indicator	30.4	30.1	30.1	36.0	41.6
Numerator	92140	117480	103011	121642	128279
Denominator	303090	390299	342229	338186	308026
Data Source					CO Department of Health Care Policy and Financing
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	42	44	46	48	50

Notes - 2008
Data shown for reporting year 2008 are for federal fiscal year 2008 for children ages 0 through 18. This is changed from data in previous reporting years which represented children ages 0 through 20.

Notes - 2007
Data shown for reporting year 2007 are for federal fiscal year 2007.

Notes - 2006
Data shown for reporting year 2006 are for federal fiscal year 2006. Data were revised (from a previous release) by CMS in May 2007.

a. Last Year's Accomplishments
The target for reporting year 2008 was 32.0 percent which was met and exceeded (using federal year 2008 data) with 41.6 percent of Medicaid eligible children receiving a dental service.

The percentage of EPSDT eligible children age six through nine who received any dental services during the year was nearly 54 percent, which nears the utilization rate of services in the insured population.

While there is no single factor responsible for the increase in Medicaid participation, several initiatives have had a contributing effect. The Oral Health Unit continued to work with dental safety net providers, the Colorado Dental Association, the Colorado Dental Hygienists Association and Oral Health Awareness Colorado! to improve dental access for Medicaid eligible children.

The State Dental Loan Repayment Program continued to be highly competitive. Using funds from the Bureau of Health Professions, Grants to States to Support Oral Health Workforce Activities, the Unit expanded loan repayment to two additional providers. Most participants see at least 40 underserved patients per month. These efforts led directly to 17,851 Medicaid-eligible

children being seen by program participants in FY 2008.

There were 398 billing providers with at least one paid claim; similar to last year. Reimbursement continues to be a major issue despite an increase in Medicaid reimbursement rates from 47 to 52 percent of the American Dental Association mean for the Rocky Mountain Region.

The Oral Health Unit continued to serve as a member of the technical assistance team for the Cavity Free at Three (CF3) initiative and participated in several implementation trainings for medical and dental providers. Cavity Free at Three seeks to improve the oral health of pregnant women and young children. Ten grants for technical assistance and to implement the model were awarded to communities.

The Colorado Department of Health Care Policy and Financing has supported amendments to its state plan that allow medical providers access to the two dental codes associated with this program, an oral health assessment and fluoride varnish application. This will be helpful in preventing caries among Medicaid-eligible children.

Colorado was successful in its application for a second five-year Centers for Disease Control's Oral Health Cooperative Agreement.

The Center for Healthy Living and Chronic Disease Prevention also participated in a pilot to integrate multiple chronic disease prevention activities within state health programs. This three-year pilot explores the coordination and integration of chronic disease interventions and risk factor control across programs, including Maternal and Child Health.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Worked with dental safety-net providers, the Colorado Dental Association, the Colorado Dental Hygienists Association and Oral Health Awareness Colorado! to improve dental access for Medicaid eligible children.	X	X	X	X
2. The State Dental Loan Repayment program continued.	X	X	X	X
3. Participated in the Cavity Free at Three Program.	X	X	X	X
4. Participated in the Medical Home Advisory Task Force to assure oral health is integrated, per legislation, into the Medical Home Concept.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2009 is for 42.0 percent of Medicaid-eligible children to receive a dental service.

Activities previously described continued.

The Oral Health Unit continued to work with Oral Health Awareness Colorado!, a statewide oral health coalition, to retain the provider reimbursement increase that was achieved last year.

The Unit is working with the Colorado Department of Health Care Policy and Financing to ensure that Medicaid oral health data are accurate and provided in a timely manner.

c. Plan for the Coming Year
The target for reporting year 2010 is for 44.0 percent of Medicaid eligible children to receive a dental service.

Current activities will continue.

The Oral Health Unit will work with Early Childhood Councils that are interested in integrating oral health into the Early Childhood Colorado Framework that is a collective vision on behalf of Colorado's young children and their families.

The Unit will develop an MCH Action Guide directed at increasing the early assessment and referral of preschool children to oral health care.

State Performance Measure 3: *The percentage of women with inadequate weight gain during pregnancy*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	23	22.5	22.3	22	20.7
Annual Indicator	22.9	24.5	18.7	27.5	26.3
Numerator					
Denominator					
Data Source					Birth certificates
Is the Data Provisional or Final?				Provisional	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	25	25	25	24	24

Notes - 2008
Data shown for 2008 are from 2007 Colorado birth certificate data. These represent term, singleton births to Colorado residents delivering in Colorado during calendar year 2007. Data shown for previous reporting years are Pregnancy Risk Assessment Monitoring System (PRAMS) survey data.

Notes - 2007
Data shown for 2007 are from the 2006 Pregnancy Risk Assessment Monitoring System (PRAMS).

Notes - 2006
Data shown for 2006 are from the 2005 Pregnancy Risk Assessment Monitoring System (PRAMS).

a. Last Year's Accomplishments
The target for reporting year 2008 was 20.7 percent and it was not met (using calendar year 2007 data). The annual indicator shows that 26.3 percent of women gained an inadequate amount of weight during pregnancy.

With the release of Tipping the Scales: Weighing in on Solutions to the Low Birth Weight Problem in Colorado in 2000, a long-term effort to reduce the incidence of inadequate weight gain (IWG)

during pregnancy was initiated. According to the Tipping the Scales population attributable risk analysis, inadequate prenatal weight gain has a significant impact on the low birthweight rate. The report states that Colorado's low birthweight rate among singleton births could be reduced by nearly a full percentage point if all women gained the recommended amount of weight during pregnancy.

The Women's Health Unit continued social marketing campaign activities from the previous year. Initially, the campaign was called "A Healthy Baby Is Worth the Weight." In 2007 the tagline was changed to "Healthy Baby Campaign." The change allowed the campaign to expand and include smoking cessation outreach and an appropriate weight gain emphasis, expanding beyond an inadequate weight gain focus.

An MCH Healthy Baby Action Guide was developed that offers strategies to address both appropriate weight gain during pregnancy and prenatal smoking cessation. It is at http://www.cdphe.state.co.us/ps/mch/actionguides.html.

Seven of 15 local health departments incorporated components of the Healthy Baby Campaign as part of their MCH operational plans. Some of the agencies elected to focus on consumer outreach and placement of billboards, busboards and radio or television advertisements. Other local health agencies conducted provider trainings and provided toolkits for use in clinical provider settings.

The website www.healthy-baby.org continued to be available to providers and consumers. The site is a resource to augment the social marketing approach. Website activities and features continued from the previous year.

Women's Health staff participated on the HealthyWomen HealthyBabies Preconception Care (PCC) Workgroup. HWHB is a collaborative organization that brings together the groups working to improve perinatal health in Colorado. The PCC workgroup's goal is to increase awareness of preconception care among Colorado health care providers and consumers.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The MCH Healthy Baby Action Guide was developed.				X
2. Ten of 15 local health departments in Colorado incorporated components of the Healthy Baby campaign as part of their MCH operational plans.	X	X	X	X
3. Website activities continued.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The target for reporting year 2009 is 25.0 percent.

The Healthy Baby Campaign website has been redesigned to reflect the broader emphasis of the larger campaign. The new website promotes emerging preconception care guidelines, gestational diabetes guidelines, and postpartum depression resources. Prenatal smoking cessation components have been added to complement the appropriate weight gain message. The website

contains both English and Spanish language content. Development of an electronic interactive version of the prenatal weight gain grid is underway. The web site is www.healthy-baby.org.

The Healthy Baby Campaign qualitative and quantitative outcome information for 2004-2007 is being analyzed and results will be available in late summer.

An analysis is underway of the reasons behind the rate decline in reporting year 2006 and the subsequent increase. The percent of women with IWG dropped significantly that year but increased the next year. The analysis is expected to show a short-term impact of the Healthy Baby campaign.

A review of the literature is being completed to identify promising practices that reduce low birthweight and promote preconception care.

Ten counties have incorporated prenatal smoking cessation and appropriate weight gain using the MCH Healthy Baby Action Guide.

Women's Health staff continue to participate on the HealthyWomen HealthyBabies Preconception Care Workgroup. That group is working to increase access to preconception care services within the state

c. Plan for the Coming Year
The target for reporting year 2010 is for no more than 25.0 percent of women to gain an inadequate amount of weight during pregnancy.

The Healthy Baby Campaign web site will be updated. The site will continue to promote preconception care and use an expanded life course perspective. An electronic interactive version of the prenatal weight gain grid will be made accessible to consumers through the web site. The Women's Health Unit will explore the development, cost, implementation and evaluation of an electronic medical record (EMR) and/or PDA prenatal weight gain grid interface. The EMR interface will be developed for providers and used as a Healthy Baby Campaign promotion tool.

A survey of obstetricians, midwives, and family practice providers will be conducted to estimate what percentage of practitioners use Institute of Medicine (IOM) weight gain recommendations when counseling pregnant women about weight gain.

Campaign materials will be updated to reflect the new IOM prenatal weight gain recommendations. Consumer and provider outreach will continue via local health agency and state health agency activities. Professional presentations that promote the Healthy Baby Campaign will continue. Consultation and technical assistance will be provided to local health agencies choosing to use Healthy Baby strategies in their MCH plans.

Women's Health staff will continue to participate in the HealthyWomen HealthyBabies Preconception Care Workgroup to improve birth outcomes by increasing the prevalence of preconception counseling among women in Colorado.

Additional strategies will be developed using information from the literature review on promising practices to reduce low birthweight and promote preconception care.

An updated population attributable risk (PAR) analysis will be conducted to determine the major contributors to low weight births in Colorado in 2007 and 2008.

State Performance Measure 5: *The motor vehicle death rate for teens 15-19 years old.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			28	18	17
Annual Indicator	29.0	31.2	18.6	19.0	17.0
Numerator	99	107	65	67	61
Denominator	341500	342486	348573	352852	358249
Data Source					2007 death certificates
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	16	15	14	13	12.5

Notes - 2008
Data shown for reporting year 2008 are calendar year 2007 data representing deaths from all motor vehicle injuries for teens age 15 through 19. The data were retrieved from the Colorado Health Information Dataset (CoHID) at http://www.cdphe.state.co.us/cohid/.

Notes - 2007
Data shown for reporting year 2007 are 2006 calendar year data.

Notes - 2006
Data shown for reporting year 2006 are 2005 calendar year data.

a. Last Year's Accomplishments
The target rate for reporting year 2008 was 17.0 deaths per 100,000 teens and it was met (using calendar year 2007 data). A total of 61 deaths among teens 15-19 years old were due to motor vehicle crashes.

The Teen Motor Vehicle Leadership Alliance public private state local partnership met monthly to coordinate the implementation of their workplan.

The Alliance distributed 65,000 brochures in English and Spanish to teens and their parents.

New teen driving toolkits were created and posted on the Colorado Teen Driver website (www.coteendriver.com) and were distributed quarterly to schools.

The Alliance provided technical assistance and consultation to statewide and local community organizations interested in or currently addressing teen motor vehicle safety. The Alliance helped two new teen driving coalitions access resources for their communities by orienting them to the Colorado Teen Driver Website and providing information on best practice programs.

The Colorado Department of Transportation (CDOT), DriveSmart Colorado Springs and the Colorado State Patrol took the lead in developing a ten-minute video that can be used as a training tool for law enforcement personnel. The video addressed the nuances of the Graduated Driver's License (GDL) law and encourages officers to enforce it. This "Roll Call" video is designed for use at a staff meeting. It has been distributed across the State.

The Alliance conducted a 90-minute session at the Colorado Association of School Resource Officer's Conference in July focused on the Colorado's GDL law and how to conduct school-based traffic safety programs.

The Injury, Suicide and Violence Prevention Unit (ISVP) created a best practice document at http://www.colorado.gov/bestpractices.

The Teen Motor Vehicle Hospitalizations Fact Sheet was updated and posted at http://www.cdphe.state.co.us/pp/injuryprevention.

A Teen Motor Vehicle Safety Learning Community was convened.

The MCH Action Guide for this area is at http://www.cdphe.state.co.us/ps/mch/actionguides.html.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participated in the Teen Motor Vehicle Leadership Alliance.				X
2. Implemented a social marketing campaign to educate and motivate law enforcement, parents, and youth to follow Colorado's GDL Law.			X	X
3. The Alliance provided technical assistance and consultation to statewide and local community organizations interested in or currently addressing teen motor vehicle safety.			X	X
4. Developed and distributed educational materials.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The 2009 target rate is 16.0 per 100,000.

The Alliance distributed 43,500 brochures in English and Spanish to teens and their parents.

New teen driving toolkits were created and posted on the Colorado Teen Driver website and distributed quarterly to schools.

A sample school seatbelt policy was developed with adult and youth input. This policy is being tested in two schools and will be promoted statewide when completed.

The Alliance created pocket-sized Colorado GDL law "cheat sheets" and distributed 5,000 copies to traffic officers statewide.

The Alliance participated in activities that led to legislation prohibiting the use of cell phones while driving for teens and prohibits all drivers from text messaging while driving.

A teen motor vehicle resource directory was created for local communities containing evidence-based programs, evaluation tools and other resources for implementing teen motor vehicle safety strategies.

The ISVP Unit hosted a Colorado Child and Adolescent Motor Vehicle Safety meeting for state and local partners addressing teen motor vehicle safety issues.

An ISVP staff member presented at the CDC's World Report on Child and Adolescent Injury Prevention meeting.

In the Annual Legislative Report, the Colorado Child Fatality Prevention State Review Team

recommended the establishment of a statutory requirement that allows for primary enforcement of the seat belt law and increased parental awareness and support enforcement of the Graduated Drivers Licensing Law.

c. Plan for the Coming Year
The target rate for reporting year 2010 is for no more than 15.0 motor vehicle deaths per 100,000 teens age 15 through 19 years old.

The state health department will continue to convene the Teen Motor Vehicle Leadership Alliance.

The Alliance will continue to work with the Colorado Department of Transportation, Division of Motor Vehicles, insurance companies, and schools to support parents. It will also update and distribute the social marketing campaign materials and provide guidance regarding enforcement of the GDL law.

The Alliance will provide information in response to primary seatbelt legislation if it is proposed in the 2010 legislative session.

The Alliance will partner with the Colorado Department of Transportation to create a new local communities section on the Colorado Teen Driver website to promote evidence-based practices and encourage coordination of teen motor vehicle safety efforts around the state. Local communities working on teen motor vehicle safety issues will continue to find links to evidence-based programs, program evaluation tools, and other resources helpful for implementing teen motor vehicle safety strategies.

State Performance Measure 7: *The proportion of all children 2-14 whose BMI is at or above 85% of normal weight for height.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			28.6	28.6	27
Annual Indicator	28.6	28.8	27.5	25.8	28.7
Numerator					
Denominator					
Data Source					Colorado Child Health Survey
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	28	28	27	27	26

Notes - 2008
Data shown for reporting year 2008 are calendar year 2008 Colorado Child Health Survey data for children ages 2-14.

Notes - 2007
Data shown for reporting year 2007 are calendar 2007 Colorado Child Health Survey data for children age 2-14.

Notes - 2006

Data shown for reporting year 2006 are calendar 2006 Colorado Child Health Survey data.

a. Last Year's Accomplishments
The target for reporting year 2008 was 27.0 percent and it was not met (using calendar 2008 data). The annual indicator shows that 28.7 percent of children ages 2-14 had a BMI at or above 85% of normal weight for height.

The Colorado Heights and Weights Project conducted a joint venture with the state health department's Oral Health Unit. Primary grade students from 49 selected schools participated in a systematic collection of height and weight BMI measurements while receiving dental screenings. The BMI data was analyzed by the Rocky Mountain Prevention Research Center and reports were developed for each participating school. Using this data, two schools received Coordinated School Health grant funding. Others schools used the information to enhance wellness committees and impact overall nutrition and physical activities in their schools.

Colorado was one of 22 states awarded a new five-year grant from the CDC's Division of Adolescent and School Health to continue Colorado Connections for Healthy Schools, Colorado's Coordinated School Health Program. The funds were used to maintain a statewide infrastructure that supported implementation of school health teams. These teams assess the school health environment, policies and programs, and implement proven strategies and activities to positively impact the health of students, especially impacting physical activity and nutrition.

Braided funding from Colorado Connections for Healthy Schools, The Rocky Mountain Center for Health Promotion, the Tobacco Prevention Program and the Colorado Physical Activity and Nutrition Program, Maternal and Child Health was used to support the development of school health teams in 30 schools throughout Colorado.

Mulitple sources of funding also supported the development of a comprehensive guide for schools and
communities to develop health teams focused on improving the school health environment. The Colorado Roadmap to Healthy Schools is at http://www.rmc.org/CSH/roadmap.html.

The Child Adolescent and School Health Unit staff and the state health department's Health Statistics Section used data from the Colorado Child Health Survey to develop a brief entitled, "Parent Support for Healthy School Environments." The brief summarized statewide parent support for healthy school programs and policies, including physical education, nutritious food offerings, and comprehensive health education. The document was shared with community partners, schools, parent groups, and policy makers. It is at www.cde.state.co.us/cdeprevention/download/pdf/parents_support_healthy_school_environments.pdf.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Participated in coalition activities.			X	
2. Colorado was awarded a new five-year grant from the CDC's Division of Adolescent and School Health to continue Colorado Connections for Healthy Schools, the Colorado Coordinated School Health Program.	X	X	X	X
3. Developed and distributed a Parent Support for Healthy School Environments brief.			X	
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
The target for reporting year 2009 is 28.0 percent.

Colorado Connections for Healthy Schools, the Colorado Coordinated School Health Program, and the CASH Unit engaged interested stakeholders, foundations, public health agencies, community organizations, academic partners and schools in multiple efforts to address childhood obesity such as assisting communities and schools to be resources to children and families.

The CASH Unit also supported efforts between public health agencies and community partners to develop and implement best practice strategies that impact policies and programs promoting healthy nutrition and physical activity for children and youth.

A total of $10,000 in joint funding were used to develop more school health teams statewide.

Local public health agencies were encouraged to adopt best practice strategies for addressing childhood overweight and obesity as part of their MCH planning.

The Unit produced an on-line resource for child growth and development information based on a series of growth and development cards, available at http://www.cdphe.state.co.us/ps/cash.

An MCH Action Guide entitled "Working Effectively with Schools to Reduce Childhood Obesity," was developed. It is at http://www.cdphe.state.co.us/ps/mch/index.html.

The Unit contracted with Metropolitan State College of Denver to conduct an environmental scan of early childhood obesity prevention efforts in early learning environments. The scan will be available in the summer of 2009.

c. Plan for the Coming Year
The target for reporting year 2010 is for no more than 28.0 percent of children ages 2-14 to have a BMI at or above 85% of normal weight for height.

The CASH Unit will continue to promote the importance of preventing early childhood obesity through multiple venues and will explore the possibility of developing an Early Childhood Obesity Prevention State Plan.

The MCH Action Guide, Working Effectively with Schools to Reduce Childhood Obesity, will be promoted to local public health agencies addressing childhood obesity.

The CASH Unit will continue to create additional child growth and development on-line resources. It will also work with the Colorado Department of Education to develop and enhance screening, referral, and health promotion efforts for students with health issues including obesity.

State Performance Measure 8: *Percent of children who have difficulty with emotions, concentration, or behavior.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			28	28	27
Annual Indicator	28.5	29.2	25.3	28.2	24.2
Numerator					
Denominator					
Data Source					Colorado Child Health Survey
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	24	24	23	23	22

Notes - 2008
Data shown for reporting year 2008 are calendar year 2008 Colorado Child Health survey data for children age 1-14.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2007 Colorado Child Health survey data for children age 1-14.

Notes - 2006
Data shown for reporting year 2006 are calendar year 2006 Colorado Child Health survey data.

a. Last Year's Accomplishments
The target for reporting year 2008 was 27.0 percent and it was met (using calendar year 2008 data). The annual indicator shows that 24.2 percent of children had difficulty with emotions, concentration, or behavior.

This was the final year for Maternal Child Health's leadership with Colorado LINKS (Linking Intergency Networks for Kids' Services) for Mental Health. As part of the integration priority for LINKS, six state agency executive directors and Governor Ritter signed a commitment statement to coordinate efforts related to behavioral health in children and youth in Colorado. The statement outlined agreements that should lead to systems enhancement and better use of resources. The workgroup also identified regulation changes that, if enacted, would improve integration of behavioral health efforts.

On May 14, 2008, almost 100 behavioral health stakeholders participated in the LINKS third annual meeting to do action planning for the three priority areas: integration of state-level behavioral health efforts; family and youth involvement in policymaking and developing innovative mechanisms for budgeting, funding and financing within and between state agencies. Presenters and panelists included First Lady Jeannie Ritter and other professional, family and youth leaders. The information gathered in the breakout groups was used to inform next steps for the LINKS Initiative, including the development of a technical assistance guide for boards/councils on how to effectively engage young people and family members.

Formal memoranda of agreements to focus on the three LINKS priorities and to coordinate behavioral health efforts were developed and signed. Descriptive language such as "involving youth in activities' was also developed for insertion into proposals or applications A virtual clearinghouse of information and tools for local communities was developed that includes examples of current behavioral health activities; lessons learned while doing behavioral health work; step-by-step guides from state and national efforts; and tools addressing cultural responsiveness, assessment and evaluation.

The Budget, Funding and Finance Leadership Team developed a white paper on fiscal coordination. A combination of fiscal and program staff from multiple state agencies worked together to advance fiscal coordination efforts to support children with mental health and co-occurring needs. It offered recommendations for change based on the identified barriers and the cost/benefit analysis that was previously shared with state agencies and interagency groups. The white paper was disseminated to partner agencies.

The 2006 Colorado Child Health Survey noted that 28 percent of parents reported concerns about difficulties with their child's emotions, concentration, behavior or getting along with others. However, of those parents, 64 percent had never used counseling or supports to address the difficulties. Although not all children with challenging behaviors require mental health treatments, many need the support of professionals who have training in mental health issues as they relate to young children. Families and child care providers also benefit from receiving consultative services, i.e. care coordination, education and support.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Developed and finalized white paper on budget, funding and finance reform.			X	X
2. Established MOUs and cross-agency agreements.				X
3. Hosted the third LINKS statewide meeting.			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The reporting year 2009 target is 24.0 percent.

Conversations occurred between CASH Unit staff and state early childhood mental health experts regarding refining this measure. A revised state performance measure would use the group of children in need (defined as those with moderate or severe difficulty) and estimate the percent that are currently receiving care. The percent receiving care should increase over time, as more children are able to access care. The current state performance measure looks at all children and provides the percent that are having difficulty with emotions, concentration, or behavior. MCH does not have control over how many children in the population have difficulties with emotions, concentration or behavior. Combined 2005-2007 Child Health Survey data indicated that about 39 percent of all children with moderate or severe difficulties were currently receiving counseling or treatment. The revised measure will be proposed as a change in the next MCH block grant application.

The Colorado Youth Development Team (CYDT) was developed to impact health and mental health outcomes for youth, using a private-public partnership of young people and professionals. The group is working to infuse positive youth development strategies and practices into state and local infrastructure. Positive youth development strategies have been shown to improve health outcomes for youth. The team action plan is at www.healthyyouthcolorado.org.

c. Plan for the Coming Year

The reporting year 2010 target is for no more thn 24.0 percent of children to have difficulty with emotions, concentration, or behavior.

The Child, Adolescent and School Health Unit will nurture collaborative efforts with various partners including local public health agencies, early childhood councils and statewide mental health consultants to promote early identification and intervention for children with challenging behaviors.

Staff will continue to work with Healthy Child Care Colorado to provide resources to the network of child care health consultants, who work directly with child care providers.

CASH Unit staff will incorporate a medical home approach into activities.

A five-year grant was received from The Colorado Trust Foundation to provide technical assistance to Colorado's thirty-one early childhood councils. The Unit will provide technical assistance to support the integration of physical, oral and behavioral/emotional health into the early childhood systems buiding work of these councils.

The Unit will promote the importance of early identification of and intervention for children with challenging behaviors through a variety of avenues: sponsoring health and safety in child care learning communities; revising Child Health Liaison curricula; maintaining current information and resource links on the CASH Unit web pages; and contributing articles to the CASH Unit's two quarterly e-newsletters, one which targets public health providers and key stakeholders, and the other that is specifically geared towards parents and family caregivers.

The Colorado Youth Development Team will complete an assessment of how positive youth development strategies are being implemented at the state and local levels. This assessment will consist of a statewide on-line survey, as well as community meetings in urban, suburban and rural areas. The CYDT will also provide training and technical assistance to 13 communities that are addressing positive youth development.

State Performance Measure 9: *Percent of center-based child care programs using a child care nurse consultant.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			90	92	94
Annual Indicator			88.6	90.0	95.8
Numerator			1528	1709	1104
Denominator			1724	1898	1153
Data Source					Qualistar Early Learning
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	96	98	98	98	98

Notes - 2008
Data shown for reporting year 2008 are calendar year 2008 data from the Qualistar Early Learning Survey conducted in the spring of 2009. These data are limited to child care centers, while data reported in earlier years included preschools as well as child care centers.

Notes - 2007

Data shown for reporting year 2007 are calendar year 2007 data.

Notes - 2006
Data shown for reporting year 2006 are data from the Spring 2006 Qualistar Survey.

a. Last Year's Accomplishments
The target for reporting year 2008 was 94.0 percent and it was met (using calendar year 2008 data). A total of 1,104 center-based child care programs used a child care nurse consultant.

Colorado state regulations require licensed child care programs, excluding preschools, to contract with a child care health consultant to provide training and information about health and safety within the child care setting. Data from the most recent survey of child care providers indicated that 95.8 percent of the responding programs were actively using a child care nurse consultant at these sites.

Qualistar Early Learning is a nonprofit organization that supports the statewide child care resource and referral network. The group conducts a statewide bi-annual survey of child care providers through the child care resource and referral network. Every year MCH provides funds to include three questions in the Qualistar survey regarding the use of the child care health consultant.

Healthy Child Care Colorado (HCCC) is an MCH-supported program that provides consultation, technical assistance and training to enhance the health and safety needs of young children. More information is available at http://www.cdphe.state.co.us/ps/cash/earlychild/healthychildcare.html. The HCCC Director is housed at Qualistar Early Learning and provides trainings designed to meet the needs of child care health consultants from around the state. Additionally, there is an on-line training program for child care health consultants at http://www.co.train.org.

The Child Health Liaison (CHL) course is designed to improve a child care provider's expertise in health and safety. There are two CHL models: a self-directed on-line course with an exam at the completion of all modules and, the second, a year-long course that combines face to face classroom learning with the on-line modules. In the blended model, the student completes assigned on-line modules that are coordinated with classroom activities and local public health agency staff trains enrolled child care providers to become their program's child health liaison. Each child health liaison participates in assessing and improving the overall health and safety of the child care environment, children, and staff while working with their child care center's health consultant. A pre- and posttest evaluation of the program indicates that the quality of child care in the participating centers improved after child care providers completed the course.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued contracting with Qualistar Early Learning to coordinate the Healthy Child Care Colorado Program.			X	X
2. Continued on-line Child Health Liaison Course.			X	X
3. Host three child care Health and Safety learning communities.			X	
4. Provide training for child care consultants.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The target for reporting year 2009 is for 96.0 percent of center-based child care programs to be using a child care nurse consultant.

The Child Health Liaison (CHL) program has expanded into Pueblo, El Paso and Summit counties, so there are now four CHL communities. As a result of the expansion of the CHL program, over 300 child care employees have participated in training.

The process to start a new CHL program has been documented and it is shared with local public health agencies that are planning to start their own CHL program.

To support the work of child care health consultants, a Medication Administration DVD was developed to serve as a companion resource to the recently revised Child Care Provider's Medication Administration manual. The intent of the DVD is to train the non-professional individual who is responsible for the administration of medication to infants, toddlers, preschool and school-aged children in all types of out-of-home child care, schools and camp settings. The development of the DVD was a collaborative effort with Healthy Child Care Colorado (HCCC), Colorado Department of Education, and the CASH Unit.

Since the release of the DVD in the spring of 2009, the HCCC Director has participated in 23 sessions and distributed 433 DVDs. In the fall of 2009, the DVD will be highlighted at the American School Health Association conference.

c. Plan for the Coming Year
The target for reporting year 2010 is for 98.0 percent of center-based child care programs to be using a child care nurse consultant.

The most recent Qualistar Program data collected about the use of child care health consultants will be used as the basis for this performance measure and will continue to be included in Colorado's MCH Datasets. Also, county specific information will be made available upon request.

The program will continue to fund the work of the Director of Healthy Child Care Colorado to support the statewide child care health consultant network. Technical assistance will also be provided to the local public health agencies that are offering the CHL program.

The Child, Adolescent and School Health Unit received a five-year grant from The Colorado Trust to provide technical assistance to Colorado's thirty-one early childhood councils for the purpose of supporting the foundation's Early Childhood Systems Building Health Integration Initiative. This initiative uses a comprehensive definition of health that includes physical, oral and behavioral/emotional health. The technical assistance consultant will work closely with council coordinators as they develop and implement their local health integration plan. Council coordinators are encouraged to partner with local health stakeholders to identify opportunities to improve health outcomes for Colorado's young children and integrate the use of best or emerging practices, such as the CHL model into their services.

The CASH Unit will work closely with the Epidemiology, Planning and Evaluation Branch (EPE) to replicate a study that was conducted several years ago that evaluated the satisfaction of the child care health consultant network. In that study, child care program directors and child care health consultants were separately interviewed to collect information pertaining to their perception of the success of the program. As the child care health consultant network has expanded, it is time to repeat the survey and compare findings. The first step will be to plan the evaluation process including the development of the survey tool. It is anticipated that results will be available by the summer of 2010.

Another collaborative effort between the CASH Unit and EPE will be to develop and implement a plan to evaluate community-based, blended CHL programs (includes on-line and face-to-face training) particularly as more sites are established around the state. This evaluation will collect and analyze primary and secondary data followed by the development of a work plan that outlines expansion processes and requirements to support existing programs.

State Performance Measure 10: *The proportion of high school students reporting binge drinking in the past month.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			30	29	29
Annual Indicator		30.6	30.6	30.6	31.8
Numerator					
Denominator					
Data Source					2007 High School YRBS
Is the Data Provisional or Final?				Provisional	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	29	29	29	28	28

Notes - 2008
Data shown for reporting year 2008 are fall 2007 Colorado Youth Risk Behavior Survey results.

Notes - 2007
Data shown are Fall 2005 Colorado Youth Risk Behavior Survey results first reported in 2005. No newer data are available. The YRBS Survey was conducted in the Fall of 2007, but results were not available at the time these data were submitted.

Notes - 2006
Data shown are Fall 2005 Colorado Youth Risk Behavior Survey results reported in 2005. No data are available for 2006. Survey conducted every other year.

a. Last Year's Accomplishments
The target for reporting year 2008 was 29.0 percent and it was not met (using 2007 data). The annual indicator shows that 31.8 percent of high school students reported binge drinking in the past month.

The Colorado Prevention Partners, a group funded by a Strategic Prevention Framework grant from the Substance Abuse and Mental Health Services Administration, completed their Year Four grant objectives. These objectives focused on sustaining local coalitions and sharing lessons learned in addressing underage alcohol use. Sixteen communities participated in the strategic prevention framework process. Two new substance abuse prevention coalitions, funded with Juvenile Delinquency Prevention dollars, were started in Cortez, Dolores and Montezuma Counties.

The Colorado Department of Human Services, Division of Behavioral Health. led the Underage Drinking Prevention and Reduction Workgroup. The workgroup gathered information about underage alcohol possession, consumption and enforcement statutes in Colorado. This information was used to identify gaps in services or laws in Colorado.

The workgroup also provided additional resources to address underage drinking and offered

technical assistance to communities. The Division of Behavioral Health funded the OMNI Institute to provide technical assistance to the sixteen communities participating in the Strategic Prevention Framework grant and to conduct community reviews of evidence-based programs, policy options and practices.

The workgroup also assisted in the administration of the Healthy Kids Colorado Survey by educating community coalitions about the importance of collecting data on binge drinking and other youth behaviors. Coalitions were encouraged to promote the survey to administrators at selected schools in their areas.

The Underage Drinking Prevention and Reduction Workgroup began development of a set of underage drinking data measures. They also supported the expansion, centralization, and maintenance of a social indicator dataset on underage drinking, contributing factors and consequences housed on the ASPIRE database.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued the Colorado Prevention Partners to influence teen binge drinking.				X
2. Provided technical assistance to Colorado community coalitions addressing underage drinking prevention.			X	X
3. Developed underage drinking data measures.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The 2009 target is 29.0 percent.

The workgroup supported law enforcement in carrying out Colorado's statutes regarding adults furnishing alcoholic beverages to youth through community-based education. Law enforcement officers, district attorneys and judges were encouraged to pursue the source of the alcohol when minors are cited for possession, consumption or related offenses. They also supported the development of a DUI education and treatment curriculum for youth age 20 and under. The Department of Behavioral Health is in the process of training eligible treatment providers to use the curriculum.

Strategies were developed to educate youth and parents about statutes affecting young driver's driving privileges; supporting law or liquor enforcement personnel in conducting alcohol compliance checks; educating retail outlet staff on the importance of responsible alcohol sales practices; and providing support to communities about evidence-based programs, policies and practices identified by community-based Underage Drinking Prevention Coalitions.

Five evidence-based programs were identified including: TIPS, a bartender education and training program; Project Northland, a school-based prevention program; Protecting You Protecting Me, an alcohol use prevention curriculum for grades one through five; and Reconnecting Youth, a semester-long class for at risk youth. A logic model that documents underage drinking and its relationship to alcohol-related crashes was developed.

c. Plan for the Coming Year
The reporting year 2010 target is for no more than 29.0 percent of high school students to report binge drinking in the past month.

The Underage Drinking Prevention and Reduction Workgroup will continue to implement their workplan activities.

A statewide, culturally responsive social marketing campaign that educates and supports law enforcement personnel (officers, judges and attorneys) in enforcing the underage possession and consumption of alcohol laws will be developed and implemented.

The workgroup will also provide judges and district attorneys with a brochure containing information about the DUI curriculum and other successful evidence-based program options that address underage possession and consumption violations, in addition to mandated consequences. About 200 brochures will be distributed at the Colorado Court Security Conference in Montrose, Colorado.

E. Health Status Indicators

Introduction
Brief narratives are shown below regarding each of the health status indicators.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	9.1	9.0	9.3	9.0	9.0
Numerator	6272	6172	6379	6377	6397
Denominator	69281	68475	68922	70737	70804
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data shown for 2008 are calendar year 2007.

Notes - 2007
Data shown for 2007 are calendar year 2006 data.

Notes - 2006
Data shown for 2006 are calendar year 2005 data.

Narrative:
Health Status Indicator Measure # 01A
The percent of live births weighing less than 2,500 grams

/2007/
This indicator is the same as Colorado's state outcome measure. The low birth weight rate shows an increase since reporting year 2001, with a possible start downward in the desired direction beginning in reporting year 2005. It is worthwhile to note also that the number of births reached a peak in reporting year 2004, and dropped by over 800 between 2004 and 2005. //2007//

/2008/
The low birth weight rate for reporting year 2006 was 9.3 percent, the highest low birth weight rate since 1973. The downturn in the rate from 9.1 percent to 9.0 percent reported above was not continued; in fact the rate jumped by 0.3 percentage points, a large increase. //2008//

/2009/
The low birth weight rate for reporting year 2007 was 9.0 percent, a decline from the previous year when it was 9.3 percent. The LBW rate for four out of the last five years was 9.0 percent. //2009//

/2010/ The low birth weight rate for reporting year 2008 was 9.0, the same as for the previous year. While Colorado's rate has not declined in recent years, it has not increased, which has been the case for most states. //2010//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	7.1	7.2	7.3	7.2	7.1
Numerator	4783	4784	4885	4913	4874
Denominator	66971	66259	66610	68475	68426
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data shown for reporting year 2008 are calendar year 2007.

Notes - 2007
Data shown for 2007 are calendar year 2006 data.

Notes - 2006
Data shown for 2006 are calendar year 2005 data.

Narrative:
Health Status Indicator Measure # 01B
The percent of live singleton births weighing less than 2500 grams

/2007/
The singleton low birth weight rate climbed steadily upward over the time period shown in the table, from 6.8 percent in reporting year 2001 to 7.2 percent in reporting year 2005. Unlike the low birth weight rate for all infants, which declined in 2005, the singleton rate continued to increase. //2007//

/2008/
The singleton low birth weight rate rose again, reaching 7.3 percent in reporting year 2006. While there is no long-term data available on this rate, it is likely that it is the highest in over 30 years. //2008//

/2009/
The singleton low birth weight rate declined from 7.3 percent to 7.2 percent in reporting year 2007. //2009//

/2010/
The singleton low birth weight rate declined from 7.2 percent to 7.1 percent in reporting year 2008. The rate for reporting year 2008 is tied with reporting year 2004, which has the lowest rate of the last five reporting years. //2010//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.3	1.3	1.3	1.3	1.3
Numerator	906	889	902	889	930
Denominator	69281	68475	68922	70737	70804
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data shown for reporting year 2008 are calendar year 2007.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data.

Notes - 2006
Data shown for reporting year 2006 are calendar year 2005 data.

Narrative:
Health Status Indicator Measure # 02 A
The percent of live births weighing less than 1,500 grams

/2007/
The state very low birth weight rate has remained at 1.3 percent for the past five years shown in

the table. This rate is considerably above the Healthy People 2010 0.9 percent target. /2007/

/2008/
The state very low birth weight rate remained at 1.3 percent, showing no change from recent years. //2008//

/2009/
The state very low birth weight rate remained at 1.3 percent, unchanged from the previous year and unchanged in many years. //2009//

/2010/
The state very low birth weight rate remained at 1.3 percent in reporting year 2008, which is again unchanged from previous reporting years. //2010//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	0.9	1.0	1.0	0.9	1.0
Numerator	630	657	682	639	688
Denominator	66971	66259	66610	68475	68426
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data shown for reporting year 2008 are calendar year 2007.

Notes - 2007
Data shown for 2007 are calendar year 2006 data.

Notes - 2006
Data shown for 2006 are calendar year 2005 data.

Narrative:
Health Status Indicator Measure # 02B
The percent of live singleton births weighing less than 1,500 grams

/2007/
The singleton very low birth weight rate has been 1.0 percent in four out of the last five years, dropping to 0.9 percent only in reporting year 2004. /2007/

/2008/
The singleton very low birth weight rate remained at 1.0 percent, showing no change from the previous year. //2008//

/2009/
The singleton very low birth weight rate declined to 0.9 percent in reporting year 2007, matching

the rate for reporting year 2004, and below the 1.0 percent shown for all other reporting years. //2009//

/2010/
The singleton very low birth weight rate increased from 0.9 to 1.0 in reporting year 2008. This rate matches the rates reported in reporting years 2005 and 2006. //2010//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	8.0	6.1	6.7	6.3	5.4
Numerator	77	59	66	63	55
Denominator	966203	970051	989454	1002764	1019648
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data shown for reporting year 2008 are calendar year 2007.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data.

Notes - 2006
Data shown for reporting year 2006 are calendar year 2005 data.

Narrative:
Health Status Indicator Measure # 03A
The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger

/2007/
The child death rate was 8.0 or higher between reporting years 2001 and 2004, but in 2005 the rate dropped to 6.1. This decline was sharp, and marked the first time since at least 1990 that the number of child deaths fell below 60. The major reason for the decline was a drop in motor vehicle deaths. /2007/

/2008/
The child death rate was 6.7 in reporting year 2006, rising from the 6.1 of the previous year, but still well below the levels of recent years. //2008//

/2009/
The child death rate due to unintentional injuries declined to 6.3 per 100,000 in reporting year 2007, down from 6.7 in reporting year 2006. It did not decline below the 6.1 achieved in reporting year 2005, but it remained well below the levels found four and five years previously. //2009//

/2010/

The child death rate due to unintentional injuries declined to 5.4 per 100,000 in reporting year 2008. This rate is the lowest rate achieved since reporting year 1998, when it was 10.2, nearly twice the current level. //2010//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	4.2	3.4	3.2	3.2	2.7
Numerator	41	33	32	32	28
Denominator	966203	970051	989454	1002764	1019648
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data shown for reporting year 2008 are calendar year 2007. Data were obtained from the Colorado Health Information Data Set (CoHID) at http://www.cdphe.state.co.us/cohid/.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data.

Notes - 2006
Data shown for reporting year 2006 are calendar year 2005 data.

Narrative:
Health Status Indicator Measure # 03B
The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes

/2007/
The child death rate was 4.2 or higher due to motor vehicle crashes between reporting years 2001 and 2004, but in 2005, the rate dropped to 3.4, when 33 children died. The number of children who were killed in crashes was the lowest since 1990.

The 2005 rate of 3.4 is undoubtedly the lowest since statistics have been tabulated in this way. In fact, records from the early 1970s in Colorado show at least 60 or 70 children killed each year in motor vehicle crashes. Increased efforts to protect children in cars are to be credited. In particular, the number of deaths to children age 4 or 5, required by law since July 2003 to use booster seats, dropped from an annual count of between 3 and 8 between 1990 and 2003 to 0 in 2004. /2007/

/2008/
The child death rate in reporting year 2006 declined further, to 3.2, reaching a new low point for this age group. The number of deaths, 32, was also a new low. //2008//

/2009/
The child death rate in reporting year 2007 due to motor vehicle crashes remained the same, 3.2,

as in the previous reporting year. It is notable that the rate is more than 25 percent lower than just four years previously in reporting year 2003. In 2002, the state legislature passed the child safety booster seat law, which went into effect in 2003. In addition, the introduction of univeral anchor systems (LATCH) in motor vehicles in 2002 has provided greater protection to children in crashes. //2009//

/2010/
The child death rate in reporting year 2008 declined to 2.7 per 100,000. This rate is based on 28 deaths for this age group. Both the rate and the number of deaths for reporting year 2008 are new lows. //2010//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	27.0	27.1	24.4	18.7	18.2
Numerator	178	182	170	134	134
Denominator	659748	671687	696111	717085	736038
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data shown for reporting year 2008 are calendar year 2007. Data were obtained from the Colorado Health Information Data Set (CoHID) at http://www.cdphe.state.co.us/cohid/.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data.

Notes - 2006
Data shown for reporting year 2006 are calendar year 2005 data.

Narrative:
Health Status Indicator Measure # 03C
The death rate per 100,000 for unintentional injuries due to motor vehicle crashes among youth aged 15 to 24

/2007/
The death rate for this age group was 27.1 in 2005, little different from the rate in 2004 or the rate in 2001, but lower than the rates in 2002 and 2003. An analysis of rates by single year of age show no trends over the five-year time period. Rates are highly volatile from one year to the next within each age group. /2007/

/2008/
The death rate for youth aged 15 to 24 was 24.4, the lowest rate since 1999. //2008//

/2009/
The death rate for youth due to motor vehicle crashes in reporting year 2007 dropped to 18.7.

This represents a substantial decline from the previous year, and nearly a 40 percent decline from four years previously (reporting year 2003). Changes in Graduated Driver Licensing laws (instituted in 1999) are being credited with much of the decline. In 2005, Colorado strengthened the laws to limit passengers riding with inexperienced drivers, to prohibit learners' permit holders to use cell phones while driving, and to require seatbelts for all occupants under age 18. A new driver under age 18 cannot have any passengers under age 21 until the driver has held a driver's license for at least six months. In addition, a new driver under age 18 cannot have more than one passenger under age 32 until the driver has had his license for at least one year. //2009//

/2010/
The death rate for reporting year 2008 declined to 18.2 per 100,000. This is the lowest rate seen since it was first included in this grant in reporting year 1998, when it was 27.8. //2010//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	187.4	184.0	170.7	160.9	162.2
Numerator	1811	1785	1689	1613	1654
Denominator	966203	970051	989454	1002764	1019648
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data shown for 2008 are calendar year 2007 from the Colorado Hospital Association discharge data set. Data represent nonfatal injuries to Colorado residents aged 0 through 14. The denominator represents the 2007 population ages 0 through 14 obtained from the Colorado Health Information Data Set (CoHID) at http://www.cdphe.state.co.us/cohid/.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data. The numerator is the number of injury hospitalizations among children aged 14 and younger minus the injuries that resulted in death (nonfatal).

Notes - 2006
Data shown for 2006 are 2005 calendar year data from the Colorado Hospital Association discharge data set.

Narrative:
Health Status Indicator Measure # 04A
The rate per 100,000 of all non-fatal injuries among children aged 14 years and younger

/2007/
This measure shows a steady downward trend since reporting year 2002. Between reporting year 2002 and reporting year 2005, the rate for children in this age group declined by 15 percent.

/2007/

/2008/
The rate of non-fatal injuries for children 14 and younger dropped to 170.7 in reporting year 2006. The decline since reporting year 2002 grew to 21 percent. //2008//

/2009/
The rate of non-fatal injuries for children 14 and younger declined again to 160.9 in reporting year 2007. The decline since reporting year 2003, four years previously, is 19 percent. //2009//

/2010/
The rate of non-fatal injuries for children 14 and younger increased slightly to 162.2 in reporting year 2008. This is the first increase after four years of decreases. //2010//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	35.1	32.2	28.9	24.8	22.5
Numerator	339	312	286	249	229
Denominator	966203	970051	989454	1002764	1019648
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data shown for 2008 are calendar year 2007 from the Colorado Hospital Association discharge data set. Data represent nonfatal injuries to Colorado residents aged 0 through 14. The denominator represents the 2007 population ages 0 through 14 obtained from the Colorado Health Information Data Set (CoHID) at http://www.cdphe.state.co.us/cohid/.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data. The numerator is the number of injury hospitalizations among children aged 14 and younger minus the injuries that resulted in death (nonfatal).

Notes - 2006
Data shown for 2006 are 2005 calendar year data from the Colorado Hospital Association discharge data set. Numbers include both traffic and non-traffic events and include all motor vehicle occupants, pediestrians, motorcycle drivers and passengers, bicyclists, etc.

Narrative:
Health Status Indicator Measure # 04B
The rate per 100,000 of all non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger

/2007/
This injury hospitalization rate has been variable in the most recent five years shown. The 2003

rate reached a low of 29.0 per 100,000, but jumped in 2004 to 35.1. The 2005 rate of 32.2 is midway between the two figures. /2007/

/2008/
The rate fell to 28.9 in reporting year 2006. The rate reflects an 86 percent decline since 1996, ten years earlier, when it was 53.7. //2008//

/2009/
The rate fell to 24.9 in reporting year 2007. Since reporting year 2006, the rate fell 14 percent. //2009//

/2010/
The rate fell again to 22.5 in reporting year 2008. The rate of 22.5 is nearly 50 percent lower than the rate reported ten years before for 1998 (43.3). //2010//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	175.5	170.2	153.6	144.6	140.6
Numerator	1158	1143	1069	1037	1035
Denominator	659748	671687	696111	717086	736038
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data shown for 2008 are calendar year 2007 from the Colorado Hospital Association discharge data set. Data represents nonfatal injuries to Colorado residents aged 15 through 24. The denominator represents the 2007 population ages 15 through 24 obtained from the Colorado Health Information Data Set (CoHID) at http://www.cdphe.state.co.us/cohid/.

Notes - 2007
Data shown for reporting year 2007 are calendar year 2006 data. The numerator is the number of injury hospitalizations among youth aged 15 through 24 years minus the injuries that resulted in death (nonfatal).

Notes - 2006
Data shown for 2006 are 2005 calendar year data from the Colorado Hospital Association discharge data set. Numbers include both traffic and non-traffic events and include all motor vehicle occupants, pediestrians, motorcycle drivers and passengers, bicyclists, etc.

Narrative:
Health Status Indicator Measure # 04C
The rate per 100,000 of all non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years

/2007/
This injury hospitalization rate reached a new low of 170.2 in 2005. The rate can change abruptly from year to year, as seen in the differences between 2002 and 2003 and then between 2003 and 2004. /2007/

/2008/
The injury hospitalization rate for youth posted a real decline, falling to 153.6 in reporting year 2006. This represents a 26 percent decline from ten years earlier. Much more progress has been made, however, with the younger (0-14) age group. /2008//

/2009/
The rate fell to 144.6 in reporting year 2007, a decline of 6 percent from the previous year. The reporting year 2007 rate marks the fourth consecutive decline since reporting year 2003, when the rate was 186.1. The overall change in just four years amounts to a decline of 22 percent. //2009//

/2010/
The rate fell again in reporting year 2008 to 140.6. Since this rate was first included in the block grant in reporting year 1998 it has fallen 29 percent (from 196.8). //2010//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	20.6	22.3	23.1	25.6	25.4
Numerator	3399	3698	3916	4452	4437
Denominator	165057	165861	169243	174069	174660
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final

Notes - 2008
Data for reporting year 2008 are from the CDPHE NETTS data transfer to CDC and are final for 2007. Population estimates for 2007 are from the Colorado State Demography Office 2007 population forecasts.

Notes - 2007
STD data for 2007 are from the Active STD*MIS database, based on report date and are provisional. Population estimates for 2007 are from the Colorado Demographer's Office 2007 population forecasts.

Notes - 2006
Data shown for 2006 are for calendar year 2005.

Narrative:
Health Status Indicator Measure # 05A
The rate per 1,000 women aged 15 through 19 with a reported case of chlamydia

/2007/
The chlamydia rate is variable for this age group, but has changed little over the past five years. /2007/

/2008/
The chlamydia rate of 23.1 in reporting year 2006 was similar to rates for this age group in recent years. //2008//

/2009/
The chlamydia rate of 25.6 in report year 2007 is the highest rate shown for the five reporting years. //2009//

/2010/
The chlamydia rate of 25.4 in reporting year 2008 represents finalized 2007 data. This rate is still the highest rate shown for final data since reporting year 2004. //2010//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	7.1	7.8	9.3	9.3	9.3
Numerator	5956	6500	7756	7958	7948
Denominator	834595	831151	838121	853985	855855
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final

Notes - 2008
Data for reporting year 2008 are from the CDPHE NETTS data transfer to CDC and are final for 2007. Population estimates for 2007 are from the Colorado State Demography Office 2007 population forecasts.

Notes - 2007
STD data for 2007 are from the Active STD*MIS database, based on report date and are provisional. Population estimates for 2007 are from the Colorado Demographer's Office 2007 population forecasts.

Notes - 2006
Data shown for 2006 are 2005 calendar year data.

Narrative:
Health Status Indicator Measure # 05B
The rate per 1,000 women aged 20 through 44 with a reported case of chlamydia

/2007/
The chlamydia rate for the older age group appears to be increasing. /2007/

/2008/
The chlamydia rate for women 20-44 rose to 9.3 per 1,000 in reporting year 2006. Data submitted in prior grants goes back to 1997, when a rate of 3.7 was reported. The rate has more than doubled in this time period.

/2009/
The chlamydia rate for women 20-44 was maintained at 9.3 for reporting year 2007. The rate had been increasing in previous years. //2009//

/2010/
The chlamydia rate for for women 20-44 was maintained at 9.3 for reporting year 2008. These data are final for 2007. The rate has not increased since reporting year 2006. //2010//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	70092	62848	3733	1411	2100	0	0	0
Children 1 through 4	284808	256289	14388	5565	8566	0	0	0
Children 5 through 9	339152	303728	18179	6046	11199	0	0	0
Children 10 through 14	325258	290693	18551	6018	9996	0	0	0
Children 15 through 19	358288	323775	18337	6282	9894	0	0	0
Children 20 through 24	378110	344286	16664	6349	10811	0	0	0
Children 0 through 24	1755708	1581619	89852	31671	52566	0	0	0

Notes - 2010
Data for reporting year 2008 are for calendar year 2007.

Narrative:
/2010/
Colorado has a population of nearly 1.8 million under the age of 25. It is predominately white with small minority groups. //2010//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY	**Total NOT Hispanic**	**Total Hispanic**	**Ethnicity Not**

TOTAL POPULATION BY HISPANIC ETHNICITY	**or Latino**	**or Latino**	**Reported**
Infants 0 to 1	44596	18252	0
Children 1 through 4	182977	73312	0
Children 5 through 9	215330	88398	0
Children 10 through 14	214318	76375	0
Children 15 through 19	248402	75374	0
Children 20 through 24	263105	81181	0
Children 0 through 24	1168728	412892	0

Notes - 2010
Data for reporting year 2008 are for calendar year 2007.

Narrative:
/2010/
Colorado's population has a large Hispanic representation. Nearly one-quarter of the population under the age of 25 is Hispanic. //2010//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	94	79	7	0	0	0	0	8
Women 15 through 17	2200	1890	136	40	27	0	0	107
Women 18 through 19	4457	3791	356	81	48	0	0	181
Women 20 through 34	52690	46372	2472	517	1849	0	0	1480
Women 35 or older	11332	10063	395	80	532	0	0	262
Women of all ages	70773	62195	3366	718	2456	0	0	2038

Notes - 2010
Data for reporting year 2008 are for calendar year 2007. A zero is reported for the American Indian/Alaska Native and Asian categories as data are suppressed. There are actually one or two events in those two categories.

Data for reporting year 2008 are for calendar year 2007. Total live births for all races may not add up to total deliveries in state Form 8 (70,804) because the age of the mother was unknown for some of the live births.

Narrative:

/2010/
The vast majority of births are classified as White (includes Hispanic ethnicity) and occur to women between the ages of 20 and 34. //2010//

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	15	64	0
Women 15 through 17	587	1303	0
Women 18 through 19	1678	2113	0
Women 20 through 34	31277	15095	0
Women 35 or older	8135	1928	0
Women of all ages	41692	20503	0

Notes - 2010
Data for reporting year 2008 are for calendar year 2007.

Narrative:
/2010/
A total of 29 percent of births are Hispanic. Hispanic births outnumber non-Hispanic births for women below age 20, while the reverse is true for older women. //2010//

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	433	372	45	6	7	0	0	3
Children 1 through 4	58	49	9	0	0	0	0	0
Children 5 through 9	47	47	0	0	0	0	0	0
Children 10 through 14	37	37	0	0	0	0	0	0
Children 15 through 19	185	170	9	3	3	0	0	0
Children 20 through 24	259	232	20	4	0	0	0	3
Children 0 through 24	1019	907	83	13	10	0	0	6

Notes - 2010
Data for reporting year 2008 are calendar year 2007.

Data for reporting year 2008 are calendar year 2007. Data are suppressed for a few age categories under the Asian and other/unknown categories so total children ages 0 through 24 for all races may be a bit lower than the total children ages 0 through 24 for all ethnicities.

Narrative:
/2010/
There were just over 1,000 deaths in the population below age 25. The largest number of deaths was for infants. //2010//

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	258	175	0
Children 1 through 4	36	23	0
Children 5 through 9	33	15	0
Children 10 through 14	27	12	0
Children 15 through 19	139	47	0
Children 20 through 24	201	60	0
Children 0 through 24	694	332	0

Notes - 2010
Data for reporting year 2008 are calendar year 2007.

Narrative:
/2010/
About one-third of deaths were among Hispanics. //2010//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	1377599	1237333	73189	25322	41755	0	0	0	2008
Percent in household headed by single	22.8	20.0	50.1	38.5	14.0	0.0	0.0	0.0	2008

parent									
Percent in TANF (Grant) families	1.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2008
Number enrolled in Medicaid	302075	72116	21412	2925	2908	3017	0	199697	2008
Number enrolled in SCHIP	77411	24922	4012	990	1246	583	0	45658	2008
Number living in foster home care	17014	0	0	0	0	0	0	17014	2008
Number enrolled in food stamp program	138770	0	0	0	0	0	0	138770	2008
Number enrolled in WIC	81392	33517	5363	33902	1074	145	7347	44	2008
Rate (per 100,000) of juvenile crime arrests	3361.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	5.9	3.8	7.7	9.8	3.4	0.0	0.0	0.0	2008

Notes - 2010
Data for reporting year 2008 are calendar year 2007.

Data for reporting year 2008 is repeated. Data are from the 2000 Decennial Census and no new data will be available until the next census in 2010.

The data for reporting year 2008 represent the monthly caseload for September 2008. No data is available by race/ethnicity. Data is available from http://www.acf.hhs.gov/programs/ofa/data-reports/caseload/monthly/2008_09_tan.htm. Source: US Department of Health and Human Services Administration for Children and Families.

Data for reporting year 2008 represent state fiscal year 2008. These numbers include retroactivity. The Colorado Department of Health Care Policy and Financing provided these data.

Data for reporting year 2008 represent state fiscal year 2008. These numbers include retroactivity. The Colorado Department of Health Care Policy and Financing provided these data.

Data for reporting year 2008 represent calendar year 2008.

Data for reporting year 2008 represent WIC infants and children ages 0-18 who were vouchered WIC participants in March 2009.

Data for reporting year 2008 are calendar year 2007 obtained from the Colorado Bureau of Investigation. http://cbi.state.co.us/dr/cic2k7/state%20totals/statewide_juvenile_arrests.html

Data for reporting year 2008 represent the 2006-2007 school year. Data include alternative high schools.

http://www.cde.state.co.us/cdereval/download/spreadsheet/2007Drops/2007-1-DropratesbyGenderGrade&Race.xls

Data for reporting year 2008 are for federal fiscal year 2007-2008 obtained from the Colorado Department of Health Care Policy and Financing Premiums, Expenditures and Caseload June 2008 Report at www.colorado.gov/cs/satellite/HCPF/HCPF/1209635766663.

Narrative:
/2010/
Nearly one-quarter of children in Colorado live in a household headed by a single parent. Only about one percent of children are in TANF families and one percent of children are living in foster home care. About one in five children in Colorado are enrolled in Medicaid; about one in twenty children are enrolled in the Colorado Child Health Plan Plus program (CHP+).

In a given month, about one in twenty children participate in the food stamp program. Children are only eligible for WIC until age 5; about 23 percent of children age 0-4 were enrolled in WIC.

Child race data are not available for the percent in TANF families, number living in foster home care, number enrolled in food stamp program, or the rate of juvenile crime arrests.

The percentage of high school drop-outs is highest among Black and American Indian/Native Alaskan children. //2010//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	1045888	331711	0	2008
Percent in household headed by single parent	19.0	29.0	0.0	2008
Percent in TANF (Grant) families	0.0	0.0	1.1	2008
Number enrolled in Medicaid	102378	117924	81773	2008
Number enrolled in SCHIP	31753	31018	14640	2008
Number living in foster home care	0	0	17014	2008
Number enrolled in food stamp program	0	0	138770	2008
Number enrolled in WIC	31556	49792	44	2008
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	3361.0	2008
Percentage of high school drop-outs (grade 9 through 12)	4.2	11.1	0.0	2008

Notes - 2010
Data for reporting year 2008 are calendar year 2007.

Data for reporting year 2008 is repeated. Data are from the 2000 Decennial Census and no new data will be available until the next census in 2010.

The data for reporting year 2008 represent the monthly caseload for September 2008. No data is available by race/ethnicity. Data is available from http://www.acf.hhs.gov/programs/ofa/data-reports/caseload/monthly/2008_09_tan.htm. Source: US Department of Health and Human Services Administration for Children and Families.

Data for reporting year 2008 represent state fiscal year 2008. These numbers include retroactivity. The Colorado Department of Health Care Policy and Financing provided these data.

Data for reporting year 2008 represent state fiscal year 2008. These numbers include retroactivity. The Colorado Department of Health Care Policy and Financing provided these data.

Data for reporting year 2008 represent calendar year 2008.

Data for reporting year 2008 represent WIC infants and children ages 0-18 who were vouchered WIC participants in March 2009.

Data for reporting year 2008 are calendar year 2007 obtained from the Colorado Bureau of Investigation. http://cbi.state.co.us/dr/cic2k7/state%20totals/statewide_juvenile_arrests.html

Data for reporting year 2008 represent the 2006-2007 school year. Data include alternative high schools.
http://www.cde.state.co.us/cdereval/download/spreadsheet/2007Drops/2007-1-DropratesbyGenderGrade&Race.xls

Data for reporting year 2008 are for federal fiscal year 2007-2008 obtained from the Colorado Department of Health Care Policy and Financing Premiums, Expenditures and Caseload June 2008 Report.
www.colorado.gov/cs/satellite/HCPF/HCPF/1209635766663

Narrative:
/2010/
A higher percentage of Hispanic children (compared to non-Hispanic children) in Colorado live in a household headed by a single parent.

A higher number of Hispanic than non-Hispanic children in Colorado are enrolled in Medicaid, but ethnicity was not reported for more than 81,000 children. The number of children enrolled in the Colorado Child Health Plan Plus (CHP+) is about equal between Hispanics and non-Hispanics. Ethnicity was not reported for nearly 15,000 children.

Child ethnicity data are not available for the percent in TANF families, number living in foster home care, number enrolled in food stamp program, or the rate of juvenile crime arrests.

Children are only eligible for WIC until age 5. A higher number of Hispanic than non-Hispanic children age 0-4 were enrolled in WIC.

The percentage of high school drop-outs is higher among Hispanic youth than among non-Hispanic youth. //2010//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	1035768
Living in urban areas	1152389
Living in rural areas	72279
Living in frontier areas	34547
Total - all children 0 through 19	1259215

Notes - 2010
Data are from the 2000 Census; no updates are available.

Narrative:
/2010/
Most Colorado children live in urban/metropolitan areas. A total of six percent of children live in rural areas and three percent live in counties with fewer than six persons per square mile. //2010//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	4756244.0
Percent Below: 50% of poverty	5.5
100% of poverty	12.0
200% of poverty	27.3

Notes - 2010
Data are from the Census Bureau's American Fact Finder American Community Survey 2007, C17204, age by ratio of income to poverty level in the past 12 months.

Narrative:
/2010/
One out of every four Colorado residents lives at or below 200% of the federal poverty level; one of every eight lives at or below 100% percent of the federal poverty level; and one out of every eighteen lives below 50% percent of the federal poverty level. //2010//

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	1352616.0
Percent Below: 50% of poverty	7.6
100% of poverty	16.3
200% of poverty	35.1

Notes - 2010

Data are 2007 population data from the Colorado Demographer's Office. Data represent children ages 0 through 19.

Data are from the Census Bureau's American Fact Finder American Community Survey 2007, C17204, age by ratio of income to poverty level in the past 12 months. Data represent children under age 18.

Narrative:
/2010/
One out of every three Colorado children lives at or below 200% of the federal poverty level; one of every six lives at or below 100% percent of the federal poverty level; and just under one in thirteen lives below 50% percent of the federal poverty level. //2010//

F. Other Program Activities

Toll-Free Hotline

The Family Healthline is a statewide information and referral service located at the Colorado Department of Public Health and Environment. During FY 2004, 8,501 calls were received by the Healthline resource specialist. The Healthline assists women, families, and individuals in locating free or low-cost health care services. Information is provided about other programs such as emergency shelters, food subsidies, mental health, or parenting support groups. The Healthline specialist speaks fluent Spanish and English, and arrangements are made for assisting the hearing- impaired and callers who speak other languages.

The Family Healthline specialist makes referrals, usually within each caller's own community, and can in certain instances establish a direct connection for the caller. Individuals often make repeat calls to the Healthline once they learn the extent of the referral database and the expertise of the staff. The Healthline's referral network covers many categories: low-cost or free medical care, dental health services, domestic violence counseling, and other basic subsistence resources.

The Family Healthline works closely with the Covering Kids and Families program and in some cases, assists individuals in completing the joint Medicaid/Child Health Plan Plus/Colorado Indigent Care Program application form.

Each Healthline call is recorded in a database where demographic and other call information is stored. Monthly reports are generated that detail certain caller demographics (place of residence, Spanish-speaking, etc.) and purpose of the call (Medicaid assistance, immunizations, etc.). These data are useful for program planning efforts. The database software has the capacity to track whether a call is the result of a specific state or national campaign effort. Using the database, the Healthline specialist can refer back to the original call for greater efficiency and better customer service. The database is also used to prepare summary reports.

/2007/
During FY 2005, the Healthline Resource Specialist received 6,355 calls. As of July 1, 2006, the Family Healthline services was transferred to the United Way 211 line. This joint effort will provide more complete personnel coverage for the Family Healthline. The Family Healthline specialist will continue to respond to the majority of the calls with backup provided by the United Way 211 staff. The toll free numbers will remain the same. //2007//

/2008/
Transition of the Family Healthline to United Way went relatively smoothly, however some data was lost due to the move. The following numbers for 2006 are approximate. The Family

Healthline offered 6,770 referrals over the year. Of these calls 920 calls were conducted primarily in Spanish. The top three caller needs were for Medical Dental (2362 referrals), food (1990 referrals) and financial assistance (219 Referrals).

Callers are: 86 percent women; 63 percent are unemployed; 77 percent are under 40 years of age; 50 percent are single; and 46 percent are Caucasian.

The average income of callers to the Family Healthline was $12,540 per year. Thus 86 percent of callers earned less than 50 percent of the Denver Metropolitan Statistical Area's median income, which is $56,500 for a single person household. //2008//

/2009/ Since the United Way was no longer interested in managing the Family Healthline, the program posted an RFP and a new contractor, Maximus, was retained as a result of the competitive bid process. The phone line received 8,992 calls between October 2006 to September 2007, an increase over the previous year number of 6,770 calls. //2009//

/2010/ The Family Healthline was managed by the contractor Maximus. The phone line received 10,479 calls between October 2007 to September 2008, an increase of nearly 1,500 calls compared to 2008. Fifteen percent of the calls were answered on the Spanish line. Maximus also maintained an average call abandonment rate (the proportion of calls not answered) of 6.6 precent, far less that the the standard of 10 percent. //2010//

Sudden Infant Death Program

The Colorado Sudden Infant Death Program is a statewide non-profit 501(c) 3 organization. The program's primary purpose is to provide early intervention through information and counseling to those persons affected by the sudden death of an infant. The program assures that emergency and other first responders understand SIDS and are able to provide accurate and appropriate information and referral resources to the family. Program staff provide the majority of the services to parents, relatives, friends, day care providers, and others. They are assisted by a statewide network of public health nurses, parents, and volunteers.

In FY 2004, the program received 60 information referrals on infant deaths of which 45 were reported as SIDS deaths. Within 48 hours of notification, each family and child care provider was contacted and mailed literature. Every family for whom the program has contact information receives scheduled mailings through the second anniversary of their infant's date of birth.

Over 1,289 contacts (phone and letters) were made in FY 2004. Educational presentations were provided to 248 individuals that included victim advocates, law enforcement officers, health care providers, social services staff, and coroners.

The program held 33 presentations in FY 2004 that offered general and risk reduction information related to SIDS. The presentations reached 727 individuals that included child care providers, new parents, child birth educators, and the general community.

Risk reduction information is also offered through newsletters, health fairs, and in targeted locations such as stores catering to babies.

/2007/ In FY 2005, the program received 38 referrals on infant deaths of which 27 were determined to be SIDS deaths. Over 1,850 contacts (phone and letters) were made.

Educational presentations were provided to 355 individuals that included victim advocates, law enforcement officers, health care providers, social services staff, and coroners.

The program held 18 presentations that offered general and risk reduction information related to SIDS. The presentations reached 304 individuals that included child care providers, new parents,

childbirth educators, and the general community. Risk reduction information is also offered through newsletters, health fairs, and in targeted locations such as stores catering to babies.

The number of SIDS cases reported in 2005 represents a decline from previous years (2003 - 36; 2004 - 41; 2005 - 27). Program staff will be looking into other infant deaths, especially those ruled as undetermined, in order to ascertain if this decrease is related to a diagnostic shift or truly demonstrates a decline in the overall infant mortality rate. This diagnostic shift is seen in other areas of the country and is attributed to the reluctance of some coroners to indicate SIDS as a cause of death if a baby is found in an adult bed or sleeping prone. //2007//

/2008/ There were 32 SIDS deaths in fiscal year 2006. The Colorado SIDS Program provided support to 155 families and trained 327 emergency responders in 51 trainings.

Funding for SIDS will be discontinued after this year because of MCH Block funding reductions. //2008//

Assuring Better Child Health and Development Project (ABCD)
/2008/ The CASH and HCP Units are working to implement the Assuring Better Child Health and Development Project that focuses on promoting the use of standardized developmental screening tools in primary health care settings to help increase early identification of developmental concerns. //2008//

/2009/ The CASH and HCP Units continue to provide leadership for the Assuring Better Child Health and Development Project that focuses on promoting the use of standardized developmental screening tools in primary health care settings to help increase early identification of developmental concerns. With staff support from the MCH Block Grant, as well as funding from two Colorado-based private foundations, the project is in the second of a three-year statewide rollout. //2009//

/2010/ The program manager and a trainer for Assuring Better Child Health and Development Project are housed at the Araphoe County Early Childhood Education Council. The staff are working with 25 counties to increase the use of developmental screenings. //2010//

G. Technical Assistance

/2010/ Colorado's technical assistance needs are shown on Form 15. The program is seeking assistance in evaluating systems building initiatives and asking for an overview of effective early childhood obesity prevention practices. //2010//

V. Budget Narrative

A. Expenditures

Information on annual expenditures is contained in Form 3, Form 4, and Form 5.

/2010/ FY 2008 expenditures were allocated 8.74% to Administration; 34.23% to Children with Special Health Care Needs; 33.76% to Child and Adolescent and 23.28% to Maternal and Infant Services.

Form 3
Line 1 - Federal Allocation -- The Federal allocation award in FY 2008 was slightly lower than budgeted for the year by $103,512 ($7,326,235 vs. $7,222,723).

Line 4 -- Local MCH Funds - The Federal Allocation was $103,512 lower ($7,326,235 vs. $7,222,723), therefore, anticipated 75% match requirement is less. The difference between budgeted and expended is $77,635 ($758,616 vs. $680,981) which comes from Local MCH funds.

Line 8 - Other Federal Funds - The large variation between budgeted and expended ($79,923,274 vs. $114,165,400) is due to under estimation of the Women, Infants & Children (WIC) and the Child & Adult Care Food Program (CACFP) funding. The WIC Program funds substantially increased by $26,839,826 from original estimate 2 years ago and the Child Adult Care Food Program increased by $5,536,521 from original estimate 2 years ago.

Form 4
Line 1. a. - Pregnant Women - Budgeted vs. expended did not substantially vary.

Line 1. c. - Children age 1 to 22 - Budgeted vs. expended did not substantially vary.

Line 1. d. Children with special health care needs - Budgeted vs. expended did not substantially vary.

Line 1. f. Administration -- The need for administrative dollars from State match sources (General and Cash fund) was about $242,000 less than projected in the original budget.

Form 5
Line I - Direct Health Care Services - The Colorado MCH program has been working at both the state and local levels to decrease the amount of Block Grant funding spent on direct health care services in order to increase effort at the population-based and infrastructure building levels. The state feels that a great proportion of the total MCH population is served with this approach.

Line II - Enabling Services - The Colorado MCH program has been working at both the state and local levels to decrease the amount of Block Grant funding spent on enabling services in order to increase effort at the population-based and infrastructure building levels. The state feels that a great proportion of the total MCH population is served with this approach.

Line III -- Population-Based Services -- Budgeted vs. expended did not substantially vary.

Line IV -- Infrastructure Building Services - The Colorado MCH program has been working at both the state and local levels to decrease the amount of Block Grant funding spent on direct health care and enabling services in order to increase effort at the population-based and infrastructure building levels. The state feels that a great proportion of the total MCH

population is served with this approach. //2010//

B. Budget

/2010/ B. Budget
Budget information is contained in Forms 2, 3, 4, 5, and 10.

Form 2
Line 1 - Federal allocation - is shown at $7,249,480 for 2010. Of these dollars, a total of 35.05% ($2,540,922) will be allocated for preventive and primary care for children; 33.18% ($2,405,134) for children with special health care needs, and 8.84% ($641,064) will be spent on administration. These proportions meet the MCH Block Grant requirements.

Line 3 - State MCH Funds - show state funds of $4,736,061 and local funds of $701,049 meeting the requirement that the total amount of $5,437,110 equals three-fourths of the federal allocation. The state maintenance of effort from 1989 is $4,736,061. The total state match for FY 10 is $4,736,061, which is the same amount.

Line 7 - Total state match - consists of state general funds in the amount of $3,219,813 and cash funds in the amount of $1,516,248 (genetics counseling fees). Local funds that support prenatal and child health activities conducted at local health departments total $701,049.

Line 9. c. - Other Federal Funds - the CISS grant line is the State Early Childhood Comprehensive System Grant.

Line 9. i. - Other Federal Funds - Centers for Disease Control - funds include $93,504 for Traumatic Brain Injury; $127,831 for Injury Prevention; $49,869 for Injury Surveillance; $283,884 for Enhancing State Capacity to Address Child and Adolescent Health through Violence Prevention; $69,766 for Rape Prevention; $479,546 for Sexual Violence Prevention.

Line 9. k. - Other Federal Funds - Other - funds include $753,788 for Community-Based Child Abuse Programs from the Administration for Children and Families, Office of Child Abuse and Neglect; $489,939 for Youth Suicide Prevention; and $3,235,763 of Title X funds. //2010//

Assurances:
The Colorado Department of Public Health and Environment will spend these funds as they are presented in this application.

The Colorado Department of Public Health and Environment uses a funding formula based on the total number of children and women of childbearing age and the number of low-income children and women of childbearing age to distribute the majority of available funding. However, some funds are distributed in compliance with Colorado's Procurement Rules and involve a "Request for Applications" competitive process such as for fund distribution to the School Based Health Centers program.

The department will only use these funds to carry out the purposes of Title V.

The department publishes sliding-fee schedules for all services for which charges are made. Charges will not be imposed on low-income mothers and children, and will be adjusted to reflect

the income, resources, and family size of individuals.

Department grantee audits are performed every two years, except when the grantee falls under the Single Audit Act provisions of Federal law.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.